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TO THE GOOD HEALTH OF ALL NORTH CAROLINA

DR. BERRYHILL

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THE COST of printing and binding these reports, for easy reading and reference by a busy Governor and Members of the General Assembly, is being paid by public-spirited North Carolina business men.

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CLARENCE POE, *Chairman*
North Carolina Hospital and
Medical Care Commission.

TO THE GOVERNOR AND TO THE 1945 GENERAL ASSEMBLY

FINAL REPORT OF THE NORTH CAROLINA HOSPITAL *and* MEDICAL CARE COMMISSION . . .

By the Chairman

NORTH CAROLINA
HOSPITAL AND MEDICAL CARE
COMMISSION

To His Excellency, Honorable R. Gregg Cherry
and the General Assembly of 1945

Gentlemen:—

A message of great hope, of almost infinite promise, and yet of great practicability.

Such I submit must be a summary of ten reports on general health conditions and hospital and medical care in North Carolina which I now have the honor to transmit to you.

Along with the report of the full Commission as adopted October 11, 1944, I now submit nine detailed reports from subcommittees appointed February 28, 1944, ably officered, on which both physicians and laymen have served with equal efficiency (with first the chairman and then the vice-chairman of each committee listed) as follows:

1. Hospital and Medical Care for Our Rural Population—Thos. J. Pearsall, Dr. G. M. Cooper.

2. Hospital and Medical Care for Our Industrial and Urban Population—Charles A. Cannon, Charles A. Fink.

3. Special Needs of Our Negro Population—Dr. E. E. Blackman, C. C. Spaulding.

4. Four-Year Medical School for University and Hospital Facilities—Dr. P. P. McCain, Josephus Daniels.

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5. Mental Hygiene and Hospitalization—Dr. James W. Vernon, Bishop Clare Purcell.

6. Hospital and Medical Care Plans in Other States—Dr. W. M. Coppridge, R. G. Deyton.

7. A Schoolchild Health Program—Dr. George M. Cooper, Clyde A. Erwin.

8. An Enlarged Public Health Program for North Carolina—Dr. Carl V. Reynolds.

9. A Statistical and Graphic Summary of North Carolina Hospital and Medical Care Needs—Dr. C. Horace Hamilton.

It is the opinion of such experts as State Health Officer Dr. Carl V. Reynolds that we here present the most comprehensive analysis and review ever yet undertaken of the medical and hospital needs of all our North Carolina people—urban and rural, white and black—and that such data will be invaluable in formulating all policies for better health conditions in North Carolina for years to come.

Ideals With Practicality

"Hitch your wagon to a star," said Emerson—meaning that practical men should yet have ideals.

"Hitch your star to a wagon," says Dr. Arthur E. Morgan—meaning that in order to be a working success, every ideal must be tied to earth and to everyday practicability.

Both these fine principles have been kept in mind by all 50 members of your Hospital and Medical Care Commission. Every member has ideals —but every member has also shown capacity for translating his ideals into practical achievement. And we have brought you a program which is intended to meet the hard tests of practicability which North Carolina Governors and legislatures have always mixed with their idealism.

Four Pertinent Questions Asked

From the time the North Carolina Hospital and Medical Care Commission was organized in February, 1944, to report tentatively to Governor

Broughton in October and finally to Governor Cherry and the General Assembly of 1945, we have sought to anticipate the four main questions you would expect your Commission to answer:

1. *What are present hospital and medical care conditions in North Carolina? Is a change, a great change, seriously needed?*
2. *If this is established as a fact, has a practicable program for making the change been developed?*
3. *Are the costs reasonable when compared with the results to be achieved?*
4. *Can you not only cite statistical proofs and thoroughly competent judgment, but is there some specific example right here in North Carolina where the proposed program has been translated into human-interest, flesh-and-blood Tar Heel terms, and if so, with what results?*

Three Questions Answered

Answering at once the first three questions, permit us to say—

1. *As to the need for change and improvement,* our committees have found that among the 48 states of the Union North Carolina is—

—45th in number of doctors per 1,000 population

—42nd in number of hospital beds per 1,000 population

And mainly as a result, we believe, of these two conditions as cause and effect our committees also report that North Carolina is—

—With respect to *infants*—39th in percentage of infants dying under one year of age (only 9 of the 48 states with a worse showing)

—With respect to *women*—41st in percentage of mothers dying in childbirth (only 7 of the 48 states with a worse showing)

—With respect to *men*—48th in percentage of army rejections for physical defects by latest available data (no state with a poorer showing)

(Precise percentage of rejections: April, 1942-March, 1943, *48.1%*; February-August, 1943, *56.8%*.)

Doctors Approve Program

2. *As for the practicability of the program* advocated by your Hospital and Medical Care Commission, we need only say that the best judges should be our North Carolina doctors themselves . . . and that of 65 county medical societies that have exhaustively examined the complete program since it was announced October, 1944, the vote (as reported to Secretary R. D. McMillan) has been:

Approving the program in entirety	55
Approving in part	8
Disapproving the program	2

Costs Low Compared To Benefits

3. *As to costs,* in view of the hundreds of millions North Carolina has spent for roads and schools, the $5,000,000 the Legislature is asked to appropriate for a statewide Hospital Building Fund is astonishingly small. Both the Federal government and our own North Carolina counties, cities and towns will almost surely supplement heavily all the aid the State may provide for hospital building. For the indigent sick in hospitals the 3½ million people of North Carolina combined are now asked to provide only as much ($1 a day) as one deceased North Carolinian (James B. Duke) gives them constantly through his will. All other costs in the proposed program we believe are equally reasonable.

Question Number 4 Brings Great Hope

As proud North Carolinians, let us say to your Excellency, Governor Cherry, and the honored members of our House and Senate, it has been no pleasure to your Commission to recite the proof that North Carolina so desperately needs "*More Doctors, More Hospitals, More Insurance.*"

When, however, we come to your fourth question, "Can you cite us an example where this proposed program has been translated into human-interest, flesh-and-blood Tar Heel terms . . . and if so, with what results?" then a great sunrise of hope and inspiration breaks upon the whole scene.

One of the most honored members of your Commission, Mr. I. G. Greer, as spokesman for the numerically largest religious denomination in North Carolina and its oldest social service agency, the Baptist Orphanage

at Thomasville, N. C., reveals what can be done not only with our average North Carolina stock, but even with young North Carolinians who have been more-than-normally handicapped by poverty—our orphans. First, let us repeat our earlier figures—48.1 and 56.8—as the percentage of army rejections of North Carolina draftees . . . and then let's listen to this officially signed report by Mr. I. G. Greer, superintendent of the Thomasville Baptist Orphanage, who writes February 9, 1945:

> *"Sometime ago you asked me to verify a statement I made to you regarding boys in service who grew up here in the Orphanage. At the time I think I told you we had 284 boys in uniform and that only 3 had failed to pass the physical examination. We know now that we have 318 in the service, and only 3 have failed to pass the physical examination—less than 1%.*

"Nor do our Baptist Orphanages differ from other North Carolina orphanages in this respect. From the superintendents of four other white orphanages I have just received data, making a total showing for boys of draft age who have been in these institutions as follows:

	Accepted for Service	*Rejected*
Baptist Orphanages (Mills and Kennedy)	*318*	*3*
Methodist Orphanage, Raleigh	*150*	*1*
Children's Home (Methodist), Winston-Salem	*225*	*2*
Barium Springs Orphanage (Presbyterian)	*220*	*5*
Oxford Orphanage	*225*	*5*
Totals	*1,138*	*16*

"This shows 1.4% army rejections, and with 1,873 children now in these orphanages there have been only 7 deaths in five years.

"Practically every child who enters our orphanages comes to us undernourished and in need of some kind of medical attention. This combined North Carolina orphanage record of 98.6% army-acceptance shows what might be done for both the children and older people all over North Carolina through improved medical and hospital care if the General Assembly approved such a program of 'More Doctors, More Hospitals, More Insurance' as the State's Hospital and Medical Care Commission is now advocat-

ing. If at any time you can use this statement in helping advance this much needed legislation, you have my permission."

The boys in our North Carolina orphanages are not coddled. They are not given luxuries. They are given sound nutrition and the reasonably adequate medical and hospital care from school age on as advocated by Governor Cherry and your Commission—and what do we find? Whereas the State's latest reported percentage of army rejections is 56.8 (and when the writer's youngest son went to Fort Bragg with 52 boys from your capital city, he was one of only 18 accepted) a not-expensive program of hospital and medical care provided for North Carolina orphanage boys of draft age brings an army acceptance of 98.6%!

North Carolina Can Become Famous For Low Death Rate

Deliberately as a result of a year-long study of all the data, good and bad, I would say this:

North Carolina has an almost ideal climate—seldom zero in winter or 100 in summer—and we have a remarkably sturdy middle-class population, free alike from dissipations of the idle rich and the physical deterioration of poverty-cursed slums. For these reasons of fine climate, fine physical stock, and freedom from extreme wealth and blighting poverty, our death rate has been amazingly low in spite of the absence of proper hospital and medical care.

With proper medical examination and treatment for all school children and proper hospital and medical care for all our older people, I believe that North Carolina can become nationally and even internationally famous for having the lowest death rate of any state of equal population in the American Union—with all that this would mean in increased efficiency, happiness and pride for all North Carolinians!

It is to such an inspiring opportunity for carrying North Carolina forward through adequate legislation in 1945 and 1947 that your North Carolina Hospital and Medical Care Commission presents its case!

Seven Highlights of Ten Reports

Just one more question I can hear His Excellency, the Governor, and busy members of the House and Senate asking as follows:

"Every one of your Commission Reports deserve detailed study, but in every article some one statement or paragraph stands out above all else. From all your Commission Reports suppose you had to pick out seven or eight paragraphs which you think every legislator should resolve to read, re-read and remember, no matter what else he might read or miss reading, what paragraphs would you select?"

This is perhaps the hardest of all four questions to answer but here would be my selections:

I. Farmers Need More Doctors, More Hospitals

It is upon our farm people that the lack of doctors and lack of hospitals falls most heavily. It is heavy in cost of medical service . . . in inability to get medical attention . . . in unnecessarily prolonged illnesses . . . in unnecessary deaths. In 34 North Carolina counties—all *rural* counties of course—there is now not a single hospital bed for anybody, white or black! In the matter of doctor shortage we note—

—The American standard is . . . 1 for each 1,000 people
—Urban North Carolina, 1940, had 1 for each 613 people
—Rural North Carolina, 1940, had 1 for each 3,613 people
—Rural North Carolina, 1944, had 1 for each 5,174 people

II. Industrial Workers Need the Program

The most praiseworthy "hospital insurance" plan, in effect in various North Carolina industries, has increased the demand for hospital care where the insured workers live . . . and should be expanded to cover not only industrial employees but other citizens. As a physician in a presumably typical Piedmont industrial small town testifies: "The share-croppers of Eastern Carolina are not the only people who urgently need better care. The factory workers and Negroes of this section are in need, too. Except during rare periods of prosperity, only about one-half of the people of this community are able to pay the modest fees we charge."

III. School Children Need Examination and Treatment

The need to examine and correct the defects of all school children—at private expense where possible and at public expense where necessary—as emphasized by Governor Cherry, is plain and urgent. After Pearl Harbor

the State had compulsory examination of all boys in the two upper grades and the percentage of those showing some defects was amazing—

—85% had dental defects
—16% defective in vision
—16% were underweight
—14% had diseased tonsils, etc.

A majority of the children examined in pre-school clinics each year are also found to have some defect.

A strict system of annual inspection of every school child enrolled in the schools of every county must be provided under the leadership of the State Board of Health cooperating with city and county health departments.

IV. Negroes Need Doctors, Hospitals, Insurance

The Negro death rate in North Carolina in 1940 was 146% that of the white death rate—an appalling difference . . . The State's Negro population in 1940 was 983,574 (and now probably exceeds 1,000,000) but the State has only 129 active Negro physicians—or 1 for each 7,783 Negro people . . . and only 7,760 hospital beds, or 1.7 hospital beds for each 1,000 Negroes—less than half the American standard . . . A regional Negro Medical School should be established . . . Hospital associations should be encouraged to extend the Blue Cross program to Negroes.

V. Why a Four-Year Medical School Is Needed

Average number of physicians who die or retire in North Carolina each year—50. Average need for new physicians in order to maintain present ratio approximates—100 each year. Average number of medical students graduated from North Carolina medical schools each year who are residents of North Carolina: about 65 (Duke, 20; Wake Forest, 45). The State thus needs 50% more new North Carolina doctors each year than these two excellent schools have provided.

VI. A Statewide Psychiatric Program Is Needed

Mental disorder is more prevalent than tuberculosis and poliomyelitis, and its total cost to the State is as great as all other diseases combined, yet little attention is paid to it. Now perhaps something may be done . . . From

40 to 70% of the average physician's practice is devoted to the diagnosis and treatment of disorders at least partly psychiatric in nature . . . By using the psychiatric unit of the proposed Four-Year Medical School as a "receiving hospital" and establishing one other such "receiving hospital" in the State, we can decrease the number of patients in hospitals for the insane, prevent many patients from becoming permanent wards of the State, and ultimately make a vast financial saving for the State . . . Every county hospital should also have a small number of beds (5 to 10) for psychiatric patients . . . Unless psychiatric care permeates through the entire state system of hospital care in this way, North Carolina will be sorely neglecting one of its largest problems.

VII. Types of Hospital and Health Centers Needed

A large Central Hospital of approximately 600 beds . . . A small number of District Hospitals of approximately 100 beds . . . Small Rural Hospitals of approximately 60 beds . . . Some counties with less than 12,500 population might find it practical to build small 20- or 30-bed hospitals . . . There should also be "Health Centers" in small rural communities, including diagnostic and laboratory services, facilities for minor operations, obstetrical service, and a small number of beds for cases not requiring the specialized services of a larger hospital, these health centers also to be used by the public health service in carrying on its work.

In Conclusion

In conclusion, I wish to express my thanks to all the members of the Hospital and Medical Care Commission who have labored with me in finding and interpreting the facts and in seeking to present a sound and reasonable program—"To the Good Health of All North Carolina." To my constant co-laborer, President Paul F. Whitaker of the State Medical Society, the State owes more than it will ever know. And finally the thanks of all the people are due to the two Governors under whom we have labored —to Ex-Governor J. M. Broughton who acted with characteristically prompt and adequate statesmanship when the State Medical Society appealed for State action . . . and to Governor R. Gregg Cherry who not only cheered us by immediate and vigorous endorsement of our efforts the day

after your Commission was appointed but enriched and rounded out our program by his statesmanlike insistence that any campaign for "Better Health in North Carolina" must begin with the boys and girls in our public schools and must equally safeguard the health and future of the child of the rich and the child of the poor.

Respectfully submitted,

Chairman.

Raleigh, N. C.
February 10, 1945.

THE GENESIS AND PROGRESS OF THE MOVEMENT FOR BETTER HOSPITAL AND MEDICAL CARE IN NORTH CAROLINA

I.

EARLY IN 1944 a committee of distinguished physicians, including President James W. Vernon, President-elect Paul F. Whitaker, and Past Presidents Donnell Cobb, Hubert B. Haywood and P. P. McCain of the North Carolina Medical Society, presented to Governor J. M. Broughton the following summary of the hospital and medical situation in North Carolina:

"We are immediately faced with critical shortages of general hospital facilities and trained medical personnel of all types . . . In 1941 North Carolina, the 11th largest state and the 5th most rapidly growing, stood in 42nd place, tied with South Carolina, in the number of general hospital beds per thousand population and in a comparable position in the number of doctors. In addition, we have always had in this State too few trained medical personnel—nurses, dietitians, doctors of public health, sanitary engineers, sanitarians, medical technicians, and health educators. To quote Dean Davison of Duke University Medical School, 'The South needs twice as many doctors and three times as many hospital beds, to raise medical facilities to the average for those of the country as a whole,'—which probably will not be an adequate standard for medical needs of the State in the future."

II.

To remedy this situation these eminent physicians then recommended the following three things:

> *1. The building of a large well-equipped general hospital, initially 500 to 700 beds . . . which would logically be placed adjoining the present buildings of the School of Medicine and Public Health and Navy Hospital at Chapel Hill.*

2. Smaller hospitals, well equipped for diagnostic work and treatment, set up in different sections of the State in which there are now no hospital facilities.

3. The present two-year Medical School of the University should be expanded into a four-year School of Medicine.

III.

Next, Governor J. M. Broughton presented this appeal to a full meeting of the Board of Trustees of the Consolidated University of North Carolina January 31, 1944, saying:

"It would seem wise under a suitable basis of cooperation between the Federal Government, the respective state governments, local governments and various foundations and funds to make provision for adequate medical care and service to those of our citizenship who by reason of unemployment or low income are unable to provide this service for themselves. The State Society is not only favorable to such general plan, but would be glad to join in the sponsorship of any move that may be made in this direction . . . The ultimate purpose of this program should be that no person in North Carolina shall lack adequate hospital care or medical treatment by reason of poverty or low income."

IV.

At this meeting of Trustees "Mr. Walter Murphy moved that the Trustees go on record as unanimously and enthusiastically approving the Governor's recommendations and report; and that a Commission be appointed by him to make a comprehensive study of the whole subject and submit recommendations to the next General Assembly. The motion was seconded by W. G. Clark, Carl Durham, J. C. B. Ehringhaus and others, and was unanimously approved."

V.

Next, the Executive Committee of the State Medical Society formally endorsed this whole program "in principle" as did the State Medical Society in regular annual session in Pinehurst May 1, 1944.

VI.

A 50-man Hospital and Medical Care Commission appointed by Governor Broughton to promote the program approved by the University Trustees met in Raleigh February 28, 1944, and organized (see list of members elsewhere) with capable subcommittees on the following subjects:

1. *Hospital and Medical Care for Our Rural Population*
2. *Hospital and Medical Care for Our Industrial and Urban Population*
3. *Special Needs of Our Negro Population*
4. *Four-Year Medical School for University and Hospital Facilities*
5. *Mental Hygiene and Hospitalization*
6. *Hospital and Medical Care Plans in Other States*
7. *Committee on Charts, Maps and Statistical Data*

VII.

On February 29, 1944, Hon. R. Gregg Cherry, one of the candidates for Governor, gave the movement this endorsement:

"I heartily approve the principle of the plan submitted by Governor J. M. Broughton for adequate medical care and hospital service for the people of North Carolina, including a full four-year medical course at the University of North Carolina, and adequate hospital facilities, which plan was unanimously endorsed by the Board of Trustees of the University of North Carolina at a meeting held January 31, 1944.

"I shall look forward with deep interest to the report of the commission recently appointed by Governor Broughton to make a comprehensive study of the whole subject prior to the next session of the General Assembly of North Carolina. If I am nominated and elected Governor of North Carolina, I intend to recommend that the General Assembly adopt appropriate legislation to effectuate such a program."

VIII.

On May 4, 1944, the Democratic State Convention met in Raleigh and the platform unanimously adopted "unreservedly approved" the following three measures:

> *"1. The provision of a standard Four-Year Medical Course at the University of North Carolina;*
>
> *"2. The establishment and maintenance of a large hospital center in connection with this medical school; and—*
>
> *"3. The establishment and maintenance of regional hospital centers in areas not now adequately served by existing hospital facilities."*

IX.

On October 11, 1944, the seven subcommittees, having made thoroughgoing studies of conditions and policies in this and other states since February 28, met in joint session and adopted the "More Doctors, More Hospitals, More Insurance" general Commission's Report entitled "To All the People of North Carolina—A Proposed Statewide Program of Hospital and Medical Care." (See copy herewith.)

X.

To County Medical Societies all over North Carolina, copies of this report were then sent for thorough study and debate. Reports from 65 counties sent to the secretary of the State Medical Society up to January 31, 1945, showed results as follows:

Entirely approving the plan	*55 counties*
Approving in part	*8 counties*
Disapproving in entirety	*2 counties*

XI.

In December, 1944, the Advisory Budget Commission, following an extensive hearing on the foregoing program, formally and officially advised the General Assembly as follows:

"We . . . hope that the program will be approved by the General Assembly to the end, as stated by the Governor in naming the Commission, 'that no person in North Carolina shall lack adequate hospital care or medical treatment by reason of poverty or low income.' "

To all the people of North Carolina

A proposed state-wide program of hospital and medical care . . . . .

By the Governor's Commission

More doctors
More hospitals
More insurance

"IN ORDER both to remedy the most urgent needs of today and work toward the larger program of tomorrow, three things are supremely needed—MORE DOCTORS, MORE HOSPITALS, MORE INSURANCE. These are the three mutually indispensable legs of our three-legged stool.

We cannot have enough doctors without more hospitals . . . nor enough hospitals without greater popular ability to pay for hospital service . . . and such ability to pay on the part of the poorer half of our population is impossible without insurance."

Clarence Poe, *Chairman*

IN FEBRUARY 1944, GOVERNOR J. MELVILLE BROUGHTON COMMISSIONED THE FOLLOWING CITIZENS TO SURVEY THE HOSPITAL AND MEDICAL CARE NEEDS OF OUR STATE AND TO RECOMMEND A PROGRAM TO THE PEOPLE AND LEGISLATURE OF NORTH CAROLINA:

D. Hiden Ramsay
Josephus Daniels
James A. Gray
Charles A. Cannon
C. C. Spaulding
Alexander Webb
R. G. Deyton
J. B. Slack
H. B. Caldwell
R. Flake Shaw
J. G. K. McClure
M. G. Mann
Charles Fink
I. G. Greer
John W. Umstead
S. H. Hobbs, Jr.
E. L. Sandefur
Reuben Robertson
W. G. Clark
N. C. Newbold
S. J. Ervin
Paul Bissette
C. Horace Hamilton

Thomas J. Pearsall
Mrs. Julius Cone
Mrs. W. T. Bost
Mrs. Jane S. McKimmon
Miss Flora Wakefield
Mrs. Richard J. Reynolds
Dr. Frances Hill Fox
Dr. James W. Vernon
Dr. P. P. McCain
Dr. W. M. Coppridge
Dr. Paul Whitaker
Dr. Donnell Cobb
Dr. E. E. Blackman
Dr. H. B. Haywood
Dr. W. R. Berryhill
Dr. C. C. Carpenter
Dr. W. C. Davison
Dr. G. M. Cooper
Dr. B. E. Washburn
Dr. J. B. Sidbury
Dr. Clyde Donnell
Dr. R. E. Wimberly
Dr. Roscoe D. McMillan

Bishop Clare Purcell

Clarence Poe, *Chairman*
Dr. Carl V. Reynolds, *Secretary*

The Commission Recommends:

In the office of Governor J. M. Broughton, on October 11, 1944, the "State Hospital and Medical Care Commission," appointed by him last February, met to hear reports from State Chairman Clarence Poe and six subcommittee chairmen: Dr. P. P. McCain, *Four-Year Medical School;* Charles A. Cannon, *Hospital and Medical Needs of Urban and Industrial Population;* Thomas J. Pearsall, *Hospital and Medical Care of Our Rural Population;* Dr. E. E. Blackman, *Special Needs of Our Negro Population;* Dr. W. M. Coppridge, *Hospital and Medical Programs in Other States;* Dr. James W. Vernon, *Mental Hygiene and Hospitalization.*

After discussion of all reports, the full Hospital and Medical Care Commission adopted the following statement and appeal to the people of the State.

NORTH CAROLINA
HOSPITAL AND MEDICAL CARE
COMMISSION

To the People of North Carolina:

On January 31, 1944, at a meeting of the Trustees of the University of North Carolina, Governor J. M. Broughton presented with strong approval a report from a committee of distinguished physicians (this committee including the president, president-elect and three past-presidents of the North Carolina Medical Society) appealing for a great forward step in the life and progress of North Carolina.

These distinguished leaders of the state's medical profession pointed out that North Carolina is now the 11th most populous state in the Union but is 42nd in number of hospital beds per 1000 population (only 6 states lower in rank) and 45th in number of doctors per 1000 population (only 3 states lower in rank) and joined Governor Broughton in recommending two far-reaching remedies as follows:

1. *The Expansion of the Two-Year Medical School at the University into a Standard Four-Year Medical School with a Central Hospital of 600 beds or more;*
2. *A Hospital and Medical Care Program for the entire state with this noble objective as expressed by Governor Broughton: "The ultimate purpose of this program should be that no person in North Carolina shall lack adequate hospital care or medical treatment by reason of poverty or low income."*

By unanimous action the Trustees of the Consolidated University approved this two-fold program. Almost immediately thereafter Governor Broughton named a "State Hospital and Medical Care Commission" which

has been busy ever since investigating conditions, scrutinizing defects, and weighing suggested remedies. Subcommittees were named as follows:

Four-Year Medical School for University and Hospital Facilities

Hospital and Medical Care for Our Rural Population

Hospital and Medical Care for Our Industrial and Urban Population

Special Needs of Our Negro Population

Hospital and Medical Care Plans in Other States

After nearly eight months of investigation and study the State Hospital and Medical Care Commission now presents to the people of the state the following findings and recommendations:

1. Our basic and permanent aim should never be at any time less lofty and comprehensive than the Governor's declaration approved by the 100-man Board of Trustees of the Greater University: "The ultimate purpose of this program should be that no person in North Carolina shall lack adequate hospital care or medical treatment by reason of poverty or low income."

2. In order both to remedy the most urgent needs of today and work toward the larger program of tomorrow, three things are supremely needed

A. *MORE DOCTORS*
B. *MORE HOSPITALS*
C. *MORE INSURANCE*

These are the three mutually indispensable legs of our three-legged stool. We cannot have enough doctors without more hospitals . . . nor enough hospitals without greater popular ability to pay for hospital service . . . and such ability to pay on the part of the poorer half of our population is impossible without insurance.

3. In each area we must be especially diligent to serve where need is direct and most challenging. This direct need is:

Among economic groups, *the poor*

Among occupational groups, *tenant farmers*

Among races, *the Negro*

In the two major geographical areas of the state, *Eastern North Carolina (and our mountain counties)*

Inside family groups, *mothers in childbirth and infants in the first months of existence.*

Supporting Data: North Carolina ranks 41st (only 7 states lower) in maternal deaths per 1000 live births . . . and ranks 39th (only 9 states lower) in number of infant deaths per 1000 live births. Minimum approved number of hospital beds is 4 per 1000 population, but in Eastern North Carolina and Western North Carolina number of beds per 1000 population is only:

	Whites	*Colored*
Eastern Counties	1.59	.92
Western Counties	2.43	2.38

Minimum approved number of doctors is 1 for each 1000 people, but Rural North Carolina (1940) has only 1 doctor for each 3,613 people.

4. Our program is not one of communism. It is not one of "Socialized Medicine." It will not destroy the fine relationship of doctor and patient. To "Socialized Medicine" as commonly understood it has, as someone has said, the same relation that vaccination has to smallpox—"*it prevents you from getting the real thing.*"

5. The masses of the people are determined to find some way to work steadily toward the goal set forth by Governor Broughton. To fail to help them may leave them to leadership dangerously unsound. Our desire is to help constructively—to cooperate for larger things with existing physicians, hospitals and other medical agencies. Our purpose indeed is "not to destroy but to fulfill."

6. We fully realize that such a program cannot be achieved overnight or at one session of our General Assembly. We do most confidently ask, however, that a realization of this fact shall not be used to prevent the state from doing less than the utmost it is possible to do.

For what we now face is the need not for a normal two-year gain in a program already well advanced but the imperative need for a great advance in a highly important program 20 years overdue.

7. The poor of the state have indeed heard gladly of this program. Men and women of wealth, we rejoice to say, have been equally quick to proffer their support. Just as North Carolina in 1900-1920 spent larger sums than ever before for Better Schools but found it a good investment for all classes, and again in 1920-40 greatly increased its expenditures for Better Roads with similar benefits to rich and poor alike, so we may now greatly increase our expenditures for Better Health and find all classes of North Carolinians bettered as a result.

So much for three basic health needs of our people and the spirit in which your State Hospital and Medical Care Commission has sought to find ways and means of meeting these needs. As a result of long study by your Commission and its various Subcommittees, we now recommend the following measures for approval by our people and their forthcoming General Assembly:

A. To Meet the Need for More Doctors, Better Distributed

North Carolina is faced with an imperative need both for more doctors and a better distribution of doctors. While an accepted formula is that there should be 1 doctor for each 1000 population, North Carolina has only 1 doctor for each 1,554 people . . . rural North Carolina has only 1 doctor for each 3,613 people . . . and there is only 1 colored physician for each 6,916 colored people. To remedy this situation we recommend:

A State Supported Four-Year Medical School. The Commission gives its unqualified endorsement to the proposal that the present two-year medical school at the University of North Carolina be expanded into a standard four-year medical school with a central hospital of 600 beds. North Carolina students trained in North Carolina will likely remain in North Carolina to follow their chosen profession.

Loan Funds for Medical Students. The Commission recommends that a loan fund be established by the State Legislature, particularly for promising youth, male or female, white or non-white, who wish to become physicians in North Carolina, with extra inducements provided for those who will agree to practice medicine at least 4 years in rural areas. Ability rather than wealth or social status should be the principal test for admission to the medical schools of the state.

Medical Training for Negro Youth. This Commission recognizes the high moral duty of the state to provide greatly improved opportunities for enabling capable Negro youths to become physicians serving their race, and we recommend a continuing study of various methods of achieving this end, including suggested North Carolina cooperation with adjoining states in establishing a Regional Medical School for Negroes, North Carolina to take the lead in this matter with as prompt action as possible to follow reasonably adequate time for study and investigation.

B. To Meet the Need for More Hospital Facilities

1. The Commission recommends that the state provide a total of $5,000,000 to be expended, as called for under prescribed regulations, for building and assisting counties and communities to build and to enlarge hospital and health centers wherever and whenever they are needed in the state. This is based on an eventual need of 6,000 additional hospital beds at an estimated cost of $2,500 per bed to bring the state up to an average of 4 beds for 1,000 population. The $5,000,000 would represent one-third of the estimated total cost of $15,000,000, the remaining $10,000,000 to be derived from other sources.

2. It is recommended that grants be made for the construction of new hospitals only in areas not adequately served by existing hospital facilities, and only for the purpose of supplementing or expanding the facilities of existing publicly-owned hospitals or those operated on a non-profit basis.

3. It is further recommended that no grant shall exceed 50 per cent of

the cost of construction and equipment of a new hospital or the expansion of an existing hospital; and that within such limitation the proportion of the grant to the total cost be based on economic conditions within the areas to be served, the financial ability of the local governmental unit which will own or operate such facility, and on the availability of funds from other sources.

4. Such a state-wide program to meet the urgent hospital needs of our people should include (in addition to the Central Hospital at the Four-Year Medical School):

(a) *A small number of District Hospitals* of approximately 100 beds. These hospitals would be complete in every sense of the word, and would serve both rural and urban people.

(b) *A large number of County or Rural Hospitals* of approximately 60 beds (including improvement or enlargement of existing facilities, particularly those that are already publicly owned or operated on a non-profit basis).

(c) *Health Centers* in small rural communities (available to all qualified physicians in the area) to provide simple diagnostic and laboratory services, facilities for minor operations, dental services, obstetrical service, etc., with a small number of beds for cases not requiring services of a larger hospital. Such Health Centers should also be used by the public health service in carrying on its preventive and educational work.

(d) To provide for the more adequate care of low-income persons in hospitals, we recommend that the state appropriate $1 per day for each indigent patient treated. The Duke Endowment now provides $1 and this together with $1 from the state would provide $2 per day—counties, municipalities, etc., making up the remainder of the costs.

(e) It is recommended that the Legislature provide for a permanent State Hospital and Medical Care Council of adequately qualified persons which should adopt policies designed to maintain the highest standards of service, efficiency, economy and professional excellence in the hospital building program, the medical student loan fund, and the general adminis-

tration of the state hospital and medical care program, strict provision being made to safeguard the program from political interference. To encourage continuing community pride, initiative, and support, any hospital receiving state-aid should remain under the professional, administrative and financial control of its own board of trustees elected locally from representative citizens in the community.

(f) Appropriations for public health work should be increased until the state has entirely adequate program for the prevention of disease, thus reducing needed hospital and medical care to the lowest practicable minimum.

(g) We endorse the proposal for a general examination of school children to discover remediable physical defects, such defects to be remedied at public expense in cases where parents are financially unable to pay for such treatment.

C. To Meet the Need for More Insurance

The Commission recommends that the state encourage in every practicable way the development of group medical care plans which make it possible for people to insure themselves against expensive illness, expensive treatment by specialists, and extended hospitalization. The Blue Cross Plan of hospital and surgical service, with some modifications, can meet the needs of that part of the state's population able to pay all their medical care costs. It is recommended that these Blue Cross organizations be asked to expand their services to include the general practitioner and prescribed drugs. This is particularly important for rural people who depend so heavily on the general physician. The importance of insurance for hospital and medical care in a general program such as ours can hardly be overestimated. Every citizen needs to realize that it is just as important to have insurance against sickness-disasters as against fire-disasters.

Conclusion

In conclusion we would say that no claim is made that this is a complete or perfect program. The wisdom of the General Assembly must fill in many gaps. The physicians, press and people of the state who have so generously proffered their interest and support—all are asked to help in remedying defects and improving details. We ask only that all of us shall work together to make real a new ideal of democracy. "The equal right of every person born on earth to needed medical and hospital care whenever and wherever he battles against Disease and Death." And to this end we would say:

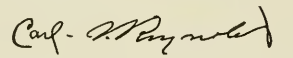
1. The family that can pay its way will do so—yet the burden on even these families should be eased through health-and-hospital insurance.

2. The family that can partly pay its way will pay this part, (likewise helped by insurance to the fullest possible degree); government and philanthropic aid being provided for the remainder.

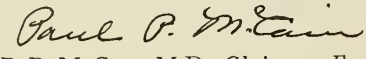
3. The family that poverty, illness, or other misfortune has left honestly incapable of paying anything for its fight against disease will nevertheless be helped to an equal chance with the rest of us as it makes the same grim battle against ever-menacing Death which we must all make and see our loved ones make sooner or later.

Signed on behalf of the State Hospital and Medical Care Commission,

Clarence Poe, *Chairman*



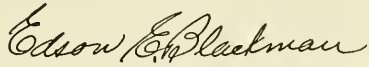
Carl V. Reynolds, M.D., *Secretary*



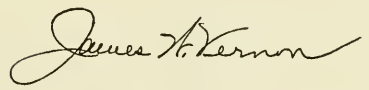
P. P. McCain, M.D., *Chairman, Four-Year Medical School for University and Hospital Facilities*

THOMAS J. PEARSALL, *Chairman, Hospital and Medical Care for Our Rural Population*

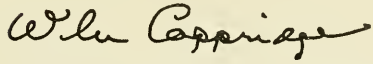
CHARLES A. CANNON, *Chairman, Hospital and Medical Care for Our Industrial and Urban Population*



E. E. BLACKMAN, M.D., *Chairman, Special Needs of Our Negro Population*



JAMES W. VERNON, M.D., *Chairman, Mental Hygiene and Hospitalization*



W. M. COPPRIDGE, M.D., *Chairman, Hospital and Medical Care Programs in Other States*

C. HORACE HAMILTON, *Chairman, Statistical Data and Publications*

THE COMMON HEALTH
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HOSPITAL AND MEDICAL NEEDS OF NORTH CAROLINA RURAL POPULATION

REPORT OF THE COMMITTEE
ON RURAL HEALTH PROBLEMS

HOSPITAL AND MEDICAL NEEDS OF NORTH CAROLINA RURAL POPULATION

REPORT OF THE COMMITTEE
ON RURAL HEALTH PROBLEMS

Report of the Committee on Hospital Facilities and Medical Care in Rural North Carolina

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FOREWORD

The medical care problem in North Carolina is to a large degree a rural problem. Nearly three-fourths of our state's population live in open country areas or in towns of less than 2,500 population. The income, particularly the cash income of our rural people, is relatively low as compared with urban population. Rural people are relatively isolated from hospitals and towns where most of the physicians live.

The rural medical problem is not a simple one. There are many deficiencies and many reasons why these deficiencies exist. In general, however, the problem has these three aspects, all of which result in poor medical care for rural people:

(1) Lack of medical care facilities and personnel
(2) Lack of appreciation for the need of good medical care
(3) The inability of rural people to pay for modern medical care

These are the three sides of the triangle: facilities, education, economics. No one phase of the problem can be considered without the other. The problem of rural medical care cannot be solved by only building hospitals, or by only educating people to know the value of good facilities, or by only providing more convenient methods of payment. *All three aspects of the problem must be worked on at once.*

More rural physicians must be trained; more rural hospitals must be built; more educational and preventive work must be carried on; and convenient methods of paying for medical care must be devised. These needs and recommendations for meeting them are outlined on the following pages.

To the North Carolina Hospital
and Medical Care Commission:

The shortage of physicians in North Carolina is alarming. Even before the war worsened the situation in 1940, the state had only 2,298 physicians. In order to provide the recommended minimum of one physician for each 1,000 people, 1,300 additional physicians are needed. Nearly all of these physicians are needed in rural areas.

In the nation, North Carolina ranks 45th in the ratio of physicians to population. Only Alabama, South Carolina and Mississippi have lower ratios than North Carolina.

The Need for Rural Physicians

The number of general physicians practicing in rural areas, or among rural people, becomes distressingly smaller every year. In 1914 there were 1,125 physicians living in rural areas of the state. By 1940 the number of rural physicians had decreased to 719. Seventy-three per cent of our state's population, but only 31% of our physicians lived in rural areas in 1940. (Rural includes all towns under 2,500 in population).

As older rural physicians retire or die, few young physicians move in to take their places. In 1914 only 14.6% of our rural physicians were over 55 years of age, as compared with 37.5% in 1940. Only 29.6% of the urban physicians were over 55 in 1940.

The tendency of young physicians to specialize accentuates the rural problem. In 1914, only 3.3% of the state's physicians were full-time specialists, as compared with 22.7% in 1940.

In the poorer rural counties and communities, the shortage of physicians is much more critical than in the richer urban counties and communities. Six large urban counties with only 20.5% of the state's population have 33.5% of the physicians. Cities above 10,000 with only 20.8% of the state's population had in 1940, 49.1% of the physicians. Only four counties in the state in 1940 had more than one physician per 1,000 people, but 43 counties had less than one physician per 2,000 people.

The distribution of physicians within counties is just as unbalanced. The physicians, quite naturally, prefer to live and work in larger towns and cities where modern hospitals are available. Many rural people now live from 10 to 20 miles from a physician. Fifty-five per cent of the area of the state is more than five miles from a physician.

There is also a poor distribution of physicians by race. The state has only 129 active Negro physicians, or 7,783 Negro people per physician.

The need of rural people for a good general practitioner who lives close to them cannot be overemphasized. General practitioners perform 79.4% of all physicians' services. Specialists perform 18.3% of the services, but account for 52.8% of the cost of all physicians' services. General physicians can and do perform many minor operations and services of specialists.

The Need for Rural Hospitals

North Carolina has 128 general hospitals, approved by the American Medical Association, containing 8,475 beds, or 2.4 beds per 1,000 population. In order to bring the hospital ratio of beds to the recommended standard of 4 beds per 1,000 people, approximately 6,000 additional beds are needed.

After allowing for unavoidable vacancies amounting to 25%, the 6,000 additional beds would provide North Carolina with 1.1 days of hospitalization per capital. In 1940 North Carolina used .52 of a day hospitalization per capita as compared with .90 for the nation and over 1.0 for states like Maryland, Minnesota, and Louisiana.

In 1940, North Carolina ranked 42nd in the nation in number of hospital beds per 1,000 population; 39th in admissions to hospitals; 40th in percentage

of hospital beds occupied; and 43rd in days of hospitalization per capita. Eighteen states had more than four general hospital beds per 1,000 population, and 18 states used more than one hospital bed per day per capita total population.

Of the 8,475 general hospital beds in North Carolina, 41.7% are locted in six large urban counties. The counties of the state, by number of beds per 1,000 population, are distributed as follows:

4 counties have 4 or more beds per 1,000 population
12 counties have from 3 to 4 beds per 1,000 population
19 counties have from 2 to 3 beds per 1,000 population
26 counties have from 1 to 2 beds per 1,000 population
5 counties have less than 1 bed per 1,000 population
34 counties have no hospital beds

At least 20 of the 34 counties without hospital beds are large enough to require a 50-bed hospital. Some of the 14 counties with less than 12,500 population might find it practical to build small 20- or 30-bed hospitals.

It is recognized, of course, that the need for a hospital in any particular community should be carefully studied before plans are drawn. A few counties can be served by hospitals in adjoining counties. There is also the problem of finding competent medical personnel to operate new hospital.s The committee assumes that a state hospital commission will be set up which, among other things, will study in detail the need for hospitals in specific communities.

The need of the Negro rural population for hospital facilities is particularly serious. At present there are only 1,665 hospital beds for Negroes, or 1.7 beds per 1,000 population. Of the 6,000 additional beds needed, 2,450 are needed for the Negro population. This estimate assumes that means will be provided to finance hospitalization for the Negro population, 75% of whom probably cannot pay all their hospital costs.

The need for hospitals is closely related to the need for physicians. The young doctor of today is trained in a well-equipped modern hospital. When he begins private practice, quite naturally, he wants to locate near a good hospital where he can put his training to the best use. Therefore, if we are to get more

physicians in rural areas, we must build small rural hospitals. There are already a number of small hospitals in rural communities and they are rendering effective service to surrounding rural areas.

The Need for Rural Clinics

In counties and communities that cannot support a full-sized hospital, there is a need for *public health centers,* or *clinics,* or *diagnostic laboratories,* the facilities of which would be equally available to all general physicians in the area. In time, as the demand grew, some of these clinics might be expanded into full-grown hospitals. For the time being, they would limit their services to simple laboratory and diagnostic service, minor surgical operations, obstetrics, and preventive work.

Many small private clinics have already demonstrated the need for such institutions. It might be well to encourage the building of more public clinics open to all physicians of the area served.

The Need for a Prepayment Plan

An individual or a family cannot know when illness or the need for an emergency operation will strike. Therefore, medical and hospital expenses cannot be planned or budgeted like such items as food, clothing, or gas for the automobile. Sickness surveys, however, do show how frequently different types of illness occur and what the costs are.

In other words, we do have an actuarial basis for medical care insurance, or for group prepayment plans. Furthermore, there is now accumulating much experience which may be used in setting up prepayment plans for farmers.

One authoritative study shows, for instance, that 1,000 persons on the average can expect, in the course of a year, 1,111 cases of illness which require medical or hospital service. Of these 1,111 cases of illness:

76.4% require only a general practitioner
3.9% require operations
23.0% require a specialist
10.6% require hospitalization
5.7% require a graduate nurse
33.0% require other nursing services

The Blue Cross Plan, sponsored by the American Hospital Association and many medical societies, provides limited hospital and surgical insurance in this state for about $30 per family. Lower rates have been made available to Farm Security borrowers but the service is more limited. Although this plan is a fine thing for those able to pay, it does not cover more than a fourth of all medical care costs.

The Farm Security Administration has developed county prepayment plans to cover the services of general practitioners; and the principle has been found to be actuarially sound and workable. Unfortunately, this plan has not been extended to help the general population but it is definitely needed.

Needs of Low-Income Groups

Although prepayment plans will go a long way towards helping low-income groups obtain more medical and hospital care, it is quite obvious that a large percentage of our population cannot afford to pay for all the medical care that they need even with the help of a prepayment plan.

Complete medical, hospital, nursing, and dental care would cost the average family in North Carolina approximately $100. This is a most conservative estimate, likely being too low rather than too high. It is based on studies of the incidence of illness and on hospital costs and physicians' fees. It does not include drugs or public health expenditures. The $100 would pay for the following items:

General practitioner	$ 18.00
Specialists	20.00
Dentists	20.00
Hospital services	18.00
Nursing services	10.00
Laboratory services	5.00
X-ray services	5.00
Eye glasses	2.00
All other	2.00
Total	$100.00

The net cash income in North Carolina in 1939 was about $600 per farm family and at least 60% of the farm families received less than that amount. Obviously no farm family can afford to pay $100 per year, or a sixth of its total cash in income for medical and hospital care. A national survey shows that:

(1) families earning over $3,000 spend over $100 per year for medical care;

(2) families earning from $500 to $1,000 spend $34 per year for medical care

If North Carolina farm families now spent 5% of their total incomes, the total amount for the farmers of the state would be about $10,000,000 in normal years. This is a little less than one-third of the amount needed for the conservative budget outlined above.

On the basis of these facts, it can be safely estimated that at least two-thirds of the farm families of the state need help in paying for adequate medical care, or in buying health insurance. Some areas will need more help than others; some low-income families can pay a part but many will not be able to pay any of their medical care costs.

The Need for Preventive and Educational Services

Curative medicine is expensive at any price. What farm people want and need most of all is a program which will keep them from getting sick in the first place. Then, if they do get sick, they need to know the advantage of using modern hospitals and well-trained doctors. They need to know the value of going to a hospital or physician before a small ailment becomes a big one. Also they need to realize the value of frequent health examinations. Finally, they need to know more about good health habits, sanitation, and *nutrition.*

Preventive health work is needed particularly in our schools through which nearly all of our people pass sooner or later. Our health examinations of school children must be made more intensively, and follow-up work must be done to see that needed treatments and corrections are carried out. Parents should be required to have serious deficiencies of their children corrected, and those not able to pay should be given financial aid by the state and county

governments. The program of health education in the schools should be strengthened in every possible way.

Although public health work in North Carolina has made substantial progress during recent years, much remains to be done. Our state is spending 16.1c and our counties are spending 37.4c per capita, but the recognized minimum standard for state and counties is one dollar per capita. Twenty-eight states spend more per capita than North Carolina on public health activities. Were it not for federal aid, North Carolina would indeed be quite deficient in its public health program. Federal aid plus foundation funds accounts for 49.9c per capita making a total health expenditure for North Carolina of $1.03 per capita.

RECOMMENDATIONS

A State-Supported Four-Year Medical School

This committee gives its unqualified endorsement to the proposal that a first-class four-year medical school be established as a part of the University of North Carolina. North Carolina students trained in North Carolina will remain in North Carolina to follow their chosen profession.

Loan Funds for Rural Medical Students

This committee recommends that a loan fund be established by the state legislature particularly for promising rural youth, male or female, white or nonwhite, who wish to become rural physicians in North Carolina. Ability rather than wealth or social status would be the principal test for admission to the medical schools of the state. These students should be required to agree to return to rural communities to practice medicine for at least four years with the understanding that one-half of their debt to the loan fund should be cancelled in return for fulfilling their agreement.

Hospital Building Program

This committee recommends that $5,000,000 be appropriated for building, and assisting counties and communities to build, hospitals and clinics whenever and wherever they are needed in the state. Careful surveys of needs should be made in every community desiring a hospital before grants are made.

This committee endorses the idea of building a large central hospital of approximately 600 beds or of such size as is needed for the size and type of medical school established.

This committee also recommends that a small number of district hospitals of approximately 100 beds be built (or that existing hospitals be enlarged). These hospitals would be complete in every sense of the word, and would serve both rural and urban people.

Most important of all, this committee recommends the establishment of a large number of small rural hospitals of approximately 60 beds. Possibly this will involve improvement or enlargement of existing non-profit facilities.

Health Centers

This committee recommends the building of health centers in small rural communities, these centers to be made available to all qualified physicians in the area. These centers would provide diagnostic and laboratory services, facilities for minor operations, obstetrical service. A small number of beds should be provided for cases not requiring the specialized services of a larger hospital. It is also recommended that these centers be used by the public health service in carrying on its preventive and educational work.

Encouragement of Group Medical Care Plans

This committee recommends that the state encourage in every practical way the development of group medical care plans which make it possible for rural people to insure themselves against expensive illness, expensive treatment by specialists, and extended hospitalization.

The Blue Cross Plan of hospital and surgical service can, with some modifications, meet the needs of that third of the state's farm population able to pay all of its health insurance.

It is also recommended that these groups be asked to expand their services to include the general practitioner and prescribed drugs. This is particularly important for rural and farm people who depend so heavily on the general physician.

Medical Care Fund

This committee recommends that there be appropriated annually approximately $3,000,000 to help the counties and other local units meet their expenses for the medical care of the indigent and low-income families. It is planned that these funds be used only in those counties willing to contribute some of their own funds. Each county should have the responsibility of expending these funds according to approved plans.

It is believed that this fund would give some medical aid to approximately 720,000 North Carolina people most in need. It would not help possibly another 720,000 who are now not getting adequate medical and hospital care.

It is planned that these funds would also be used to help those parents of school children who are unable to pay all the costs for correcting defects or in treating diseases revealed in the regular school health examinations.

State Hospital and Medical Care Commission

It is recommended that there be set up by the State Legislature a permanent hospital and medical care commission which would have charge of the hospital building program, the medical student loan fund, as well as the administration of the medical care fund.

T. J. PEARSALL, *Chairman, Hospital and Medical Care for Our Rural Population*

MEMBERS OF THE COMMITTEE

Thomas J. Pearsall, Chairman, Box 1099, Rocky Mount, N. C.

Dr. G. M. Cooper, Vice-chairman, State Health Department, Raleigh, N. C.

Dr. C. Horace Hamilton, Secretary, N. C. State College, Raleigh, N. C.

Dr. L. D. Baver, N. C. State College, Raleigh, N. C.

J. B. Slack, Farm Security Aministration, Raleigh, N. C.

Dr. W. C. Davison, School of Medicine, Duke University, Durham, N. C.

Dr. Jane S. McKimmon, N. C. State College, Raleigh, N. C.

Harry B. Caldwell, N. C. State Grange, Greensboro, N. C.

R. Flake Shaw, Farm Bureau Federation, Greensboro, N. C.

J. G. K. McClure, Farm Federation, Asheville, N. C.

Dr. B. E. Washburn, Rutherfordton, N. C.

Dr. S. H. Hobbs, Jr., Department of Sociology and Economics, Chapel Hill, N. C.

M. G. Mann, N. C. Cotton Growers Association, Raleigh, N. C.

HOSPITAL AND MEDICAL NEEDS OF THE INDUSTRIAL AND URBAN PEOPLE IN NORTH CAROLINA

REPORT OF THE COMMITTEE
ON URBAN HEALTH PROBLEMS

HOSPITAL AND MEDICAL NEEDS

OF THE INDUSTRIAL AND URBAN PEOPLE IN NORTH CAROLINA

REPORT OF THE COMMITTEE
ON URBAN HEALTH PROBLEMS

Report of the Committee on Hospital and Medical Care for Industrial and Urban Population

To the Governor's Commission
on Hospitals and Medical Care

We have found some difficulty in drawing a line between rural areas and the industrial and urban areas. Moreover, we do not believe it practical, in considering hospital needs for the population of the State, to make such a distinction. We are, therefore, using the statistics covering the entire State as a basis for our recommendations. When this report is coordinated with the other reports, any overlapping or conflicting recommendations should be eliminated.

In considering the location and needs of hospitals, the county has been considered as a unit in most cases. The reason for this is that the county under the organization of our State Government is a geographical and political unit with definite responsibilities and with large powers and resources with which to discharge its responsibilities. Moreover, most counties have assumed and are discharging these responsibilities in a praiseworthy degree. Fortunately, for the large number of our counties the population is of such size and the taxable wealth sufficient to support and make possible a hospital located in the county, convenient to the people of the county and responsive to administrative patterns of control well established by tradition and justified by experience.

Location of Hospitals

The location of the hospital, in addition to being convenient to the patients and their families, should also be located so as to be of help to the medical men in the community in their work and to encourage younger men to locate in the various counties in the State. No hospital will be rendering its maximum service if it does not furnish, in addition to the service it renders to the patients, a rallying point for the doctors and thereby improve the quality of their work and their ability to serve the community.

It may be desirable for the State Legislature to consider creating by legislative act a few hospital districts incorporating two or more counties and providing some legal apportionment or assessment of the counties involved in

the district for the raising of funds, both for the construction and operation of the hospital. Of the 34 counties without hospitals, it is thought that possibly the answer to about 1/3 of these counties is to establish hospital districts combining two or more counties in the hospital district. It is believed that 1/3 of the counties should build hospitals to take care of the requirements of their respective counties. The other 1/3 of the smaller counties would have to continue to be served as they now are through the hospital provision of their neighboring counties, or else be provided with a small cottage type of hospital capable of providing for the local doctors the diagnostic services of a laboratory and X-ray and facilities for emergency surgery and obstetrical care.

Out of the 100 counties in the State, 66 have hospitals serving 84.4% of the population, and 34 do not have hospitals serving 15.6% of the population. The counties without hospitals are to a substantial degree the rural counties. The 66 counties with hospitals cover rural and urban communities. These counties had 2.8 hospital beds per thousand population, or a total of 8,464 beds. If the State is to have the proper hospital facilities, there will have to be a substantial expansion of hospital beds in existing institutions and location of a number of new hospitals for the convenience of the patients and the doctors.

How Many Hospital Beds Do We Need?

If it is assumed that for the 34 counties without hospitals new hospitals were built with approximately 750 beds, we should have approximately 2.6 hospital beds per thousand population for the entire State, or 9,214 hospital beds. If a minimum of three beds per 1,000 population, the total hospital beds required for the State would be 10,710, leaving to be added to our existing facilities and new hospitals 1,496 beds, or approximately 1,500 beds. It is the judgment of some authorities that a minimum of four beds per thousand population is needed to meet the State-wide demand. This would require a total of 14,280 hospital beds and would require new locations and expansion of present facilities amounting to about 5,816 new beds. If the State undertakes to encourage the building of three beds per 1,000 population, or 1,500 additional beds, and if these beds can be provided at $2,000 per bed, that would mean a construction cost of $3,000,000. If the State undertakes to encourage the building of four beds per 1,000 population, the existing facilities would have

to be increased by 5,816 new beds. The cost of $2,000 per bed would be $11,632,000.

This method of estimating the number of hospitals needed on a population basis, that is, number of beds per 1,000 population to be served, is a satisfactory method for establishing a primary hospital unit, but additions to that unit should not be made on a population basis but on the basis of the percentage of existing beds in use at the average time. To illustrate: A population of 25,000 people is served by a hospital of 50 beds. Of the 50 beds, only 30 are in use at the average time, which is 60% occupancy. Under these conditions, no one would recommend three beds per 1,000 population. The two beds per 1,000 are meeting all demands.

From all available information, the existing hospitals of the State are inadequate to meet the present demands and many of the general hospitals would need some enlargement, but the extent of the enlargement would be judged not on the basis of population served but upon the per cent of beds in use at the average time.

The hospital insurance plan, which is in effect in various industries, has increased the demand for hospital care in the counties where the insured workers live. It is believed that the hospital insurance will be expanded to cover not only industrial employees but other citizens of the State as well.

Hospital Construction Loans by State

This committee recommends that the primary responsibility for the financing and operation of the hospital remain in the various communities; that in order to promote the expansion of the hospital facilities with as little delay as possible the State of North Carolina set up a loan fund; that the hospitals aided shall be operated under the direction of a Board of Directors composed of representative citizens, with the tenure of service of the members expiring at different times, some in two years, some in four years, some in six years, so as to encourage stability of policies and non-political control.

The financing of the operation of the hospital should be aided by county appropriation or local tax, this money to be used in support of the hospital and to help the county take care of its indigent sick.

NEGRO HOSPITAL AND MEDICAL NEEDS IN NORTH CAROLINA

REPORT OF THE COMMITTEE
ON NEGRO HEALTH PROBLEMS

NEGRO HOSPITAL AND MEDICAL NEEDS IN NORTH CAROLINA

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THE COMMITTEE

ON NEGRO HEALTH PROBLEMS

E. E. Blackman, M.D., Charlotte

C. C. Spaulding, Durham

R. E. Wimberly, M.D., Raleigh

Clyde Donnell, M.D., Durham

N. C. Newbold, Raleigh

Alexander Webb, Raleigh

COMMITTEE ON SPECIAL NEEDS OF OUR NEGRO POPULATION

To the Hospital and
Medical Care Commission:

The following recommendations are submitted by the Committee to study the special needs of our Negro population:

> *First,* That a unit be established for Negroes in connection with the proposed four-year Medical School at the University of North Carolina.
>
> *Second,* That hospital units be established for both races at advantageous and convenient locations, and that both white and Negro physicians be available to their patients.
>
> *Third,* That hospital associations be encouraged to extend the Blue Cross program among Negroes.

I. TRAINING NEGRO DOCTORS

1. In several meetings with small groups, three suggestions have been offered for consideration:

(a) That a medical training unit be established at Durham within the Organization of the North Carolina College for Negroes or affiliated with that institution. The library and the facilities for teaching the sciences and certain other subjects lend themselves to this kind of training to some extent at least. This institution is located near the University of North Carolina and Duke University, where already, by a cooperative arrangement, these universities through their faculties and libraries are assisting in the graduate and professional training offered to Negroes in North Carolina. The expansion of the graduate program in this college to include medicine might conceivably be worked out on standard levels and at reasonable costs.

(b) That a medical unit be established in Winston-Salem where some assistance and cooperation might be secured from the Wake Forest College (Bowman Gray Foundation) Medical School located there. It has been suggested that the present hospital for white people now located in a Negro section there might be available as a nucleus for a medical training unit for preparing Negro doctors—when a new hospital location is found and new buildings erected. Excellent hospital facilities for both races are available in Winston-Salem. The Winston-Salem Teachers' College, near to the location referred to, might offer some valuable services to such a medical training unit.

(c) That a medical unit for training Negro doctors be developed in connection with Shaw University in Raleigh. The Leonard Medical School, formerly a part of the institution, trained a considerable number of Negro doctors who have rendered fine service to North Carolina. Some of these men are still in active service. It is suggested that aid—though a little farther removed from Durham and Chapel Hill—might be available from the medical schools in those two universities—Duke University and the University of North Carolina.

Leaders among Negroes in the State believe that a "Medical school in North Carolina would attract students from surrounding states; and that the state would be discharging its own obligations in providing medical education for all its citizens. Further, the old North State Medical Society endorses the establishing of a medical school for Negroes in the State."

The Negro population of North Carolina in 1940 was 983,574. By December, 1944, it is probably beyond 1,000,000. To serve this population, "the State has only 129 active Negro physicians, or 7,783 Negro people per physician."*

The minimum recommended by competent authorities is "one physician for each 1,000 people." On this basis the million Negroes in North Carolina would need about 1,000 doctors. However, if the need is estimated upon the basis of one doctor for 2,000 people instead of the minimum of one for 1,000 as recommended by competent authorities, the number needed is 500 Negro doctors in this State. According to the data secured by Dr. Hamilton, there are only 129 doctors now, or one-fourth the number actually needed on a basis of

* Summary Report of the Committee on Hospitals and Medical Care for Rural People.

one for each 2,000 people (or twice the number of people "competent authorities" say is a doctor's population load). These figures greatly emphasize the very urgent need for more doctors if the Negro people in North Carolina are to receive even moderate medical attention.

2. In view of the magnitude of this very important matter, we suggest the appointment of a small committee of both races, including experts in the field of medical education, research, general graduate education, business and finance, race relation, who would study the problem carefully and thoroughly. The purpose of such exhaustive study would be to determine if, after investigating all the factors involved, it would be wise from all viewpoints to establish a medical unit for training doctors for the million Negro people in the State—this to be operated in connection with the proposed four-year medical college at the University of North Carolina. Such a medical unit might well be established at one of the centers mentioned above—Durham, Winston-Salem, Raleigh. The major point of this suggestion is that the persons interested in the proposed program of medical and hospital care in North Carolina, those in the leadership of the movement, the legislature, and the citizenry of the State may all know that every possible effort has been made to provide, if possible, medical training for Negro doctors within the State.

Such a complete study would include every phase of the problem, a realistic understanding of the need for 500 or more Negro doctors instead of only 129 as now, the cost of it, and the place to operate such a unit. This would make it possible for the legislature, and other leaders to determine if the wisest solution of the problem is to establish such a medical unit in North Carolina as is desired by Negroes of the State, or, if, all things considered, the out-of-state fellowship plan would be best both for the young medical trainees themselves because of the standard of services they would receive, or other reasons, and for the State because of the cost for standard training for one race of its citizens.

II. HOSPITALIZATION FOR NEGROES IN NORTH CAROLINA

Perhaps the best thing that can be said in the beginning is to quote a statement recently prepared including the most accurate up-to-date data on this

subject—for the whole state, and for both races:

White and Negro hospital beds with number of beds per thousand population in each County. Compiled from 1940 United States Census and from hospitals registered by American Medical Association and those receiving assistance from the Duke Endowment Fund.*

American Hospital Association reports that adequate number of hospital beds in nation should be 3 to 5 per thousand population.

On the basis of the total Negro population in 1940, viz.: 983,574 with a total hospital beds of 1,760, it appears there are approximately 1.7 hospital beds per 1,000 population. This shows there are fewer than fifty per cent of the hospital beds per 1,000 of population among Negroes in North Carolina than the average American standard requires. This means that each hospital bed must serve 559 people, whereas, the American standard requires one hospital bed for approximately each 250 people. The task of the state and the counties and cities is to provide two hospital beds where only one exists now.

NORTH CAROLINA "GENERAL" HOSPITAL STATISTICS
NOVEMBER 1944

	Population		Hospital Beds		Ratio Per 1000	
County	White	Negro	White	Negro	White	Negro
Alamance	46,835	10,952	36	6	0.75	0.47
Alexander	12,516	938	0	0	0	0
Alleghany	6,032	309	0	0	0	0
Anson	14,518	13,925	24	16	1.65	1.15
Ashe	22,189	475	26	1	1.17	2.01
Avery	13,302	259	78	2	5.76	7.70
Beaufort	22,632	13,799	71	14	3.14	1.02
Bertie	11,324	14,877	0	0	0	0
Bladen	16,101	11,055	0	0	0	0
Brunswick	11,331	5,794	40	10	3.53	1.75
Buncombe	92,604	16,151	381	31	4.14	1.92

* Compiled by Alexander Webb of the Hospital and Medical Care Commission.

County	Population		Hospital Beds		Ratio Per 1000	
	White	Negro	White	Negro	White	Negro
Burke	35,444	3,171	128	16	3.61	5.05
Cabarrus	49,612	9,781	106	24	2.14	2.46
Caldwell	33,037	2,768	38	4	1.76	1.45
Camden	3,195	2,245	0	0	0	0
Carteret	15,986	2,698	31	5	1.98	1.85
Caswell	10,918	9,114	0	0	0	0
Catawba	46,488	5,165	118	13	2.54	2.52
Chatham	16,814	7,912	18	0	1.06	0
Cherokee	18,631	182	23	2	1.24	10.99
Chowan	6,139	5,433	0	0	0	0
Clay	6,326	79	0	0	0	0
Cleveland	45,208	12,847	86	25	1.90	1.95
Columbus	31,227	14,436	46	13	1.47	0.91
Craven	17,265	14,033	46	59	2.67	4.20
Cumberland	39,015	20,305	175	46	4.49	2.27
Currituck	4,373	2,336	0	0	0	0
Dare	5,570	471	0	0	0	0
Davidson	47,484	5,893	63	9	1.33	1.53
Davie	12,730	2,179	0	0	0	0
Duplin	25,576	14,163	0	0	0	0
Durham	51,714	28,530	665	164	11.28	5.75
Edgecombe	22,495	26,667	48	15	2.13	0.56
Forsyth	85,318	41,157	520	279	6.69	6.78
Franklin	17,340	13,042	0	0	0	0
Gaston	74,941	12,590	112	22	1.49	1.73
Gates	5,086	4,972	0	0	0	0
Graham	6,415	3	0	0	0	0
Granville	14,383	14,961	35	16	2.43	1.07
Greene	10,044	8,504	0	0	0	0
Guilford	121,761	32,155	375	75	3.08	2.33
Halifax	24,446	32,066	77	23	3.15	0.72
Harnett	32,237	12,002	53	14	1.33	1.17
Haywood	33,913	891	75	6	2.21	6.73
Henderson	23,917	2,132	93	9	4.09	4.22
Hertford	7,905	11,447	0	0	0	0
Hoke	5,963	8,974	0	0	0	0
Hyde	4,618	3,242	0	0	0	0
Iredell	40,849	9,575	213	18	5.21	1.88
Jackson	18,757	609	27	1	1.44	1.64
Johnston	50,349	13,449	35	0	0.69	0
Jones	6,127	4,799	0	0	0	0
Lee	13,395	5,348	38	12	2.84	2.25
Lenoir	23,399	17,812	115	28	4.91	1.57
Lincoln	20,892	3,295	84	6	4.02	1.88

County	Population		Hospital Beds		Ratio Per 1000	
	White	Negro	White	Negro	White	Negro
McDowell	21,166	1,830	37	5	1.75	2.73
Macon	15,415	465	79	6	3.12	12.90
Madison	22,300	222	0	0	0	0
Martin	13,429	12,682	31	4	2.31	0.32
Mecklenburg	108,523	43,303	708	87	6.52	2.01
Mitchell	15,912	68	0	0	0	0
Montgomery	12,534	3,746	0	0	0	0
Moore	21,635	9,334	68	17	3.14	1.82
Nash	32,255	23,353	145	48	4.49	2.05
New Hanover	30,871	17,064	294	164	9.52	9.61
Northampton	10,766	17,533	0	0	0	0
Onslow	13,077	4,862	46	9	3.52	1.85
Orange	15,911	7,161	0	0	0	0
Pamlico	6,328	3,378	0	0	0	0
Pasquotank	11,804	8,764	23	7	1.95	0.80
Pender	9,491	8,219	0	0	0	0
Perquimans	5,045	4,728	0	0	0	0
Person	15,827	9,202	25	0	1.58	0
Pitt	32,158	29,086	36	14	1.12	0.48
Polk	10,231	1,643	22	4	2.15	2.45
Randolph	40,226	4,328	69	8	1.72	1.85
Richmond	24,570	12,240	45	20	1.83	1.63
Robeson	51,287	25,473	130	50	2.53	1.96
Rockingham	45,862	12,036	105	20	2.29	1.66
Rowan	56,240	12,966	100	20	1.78	1.54
Rutherford	39,445	6,132	60	10	1.52	1.63
Sampson	30,828	16,612	6	0	0.19	0
Scotland	11,168	12,064	22	8	1.97	0.66
Stanly	28,919	3,915	84	18	2.90	4.61
Stokes	20,364	2,292	0	0	0	0
Surry	39,252	2,531	104	16	2.65	6.32
Swain	11,797	380	28	0	2.38	0
Transylvania	11,400	841	20	5	1.75	5.95
Tyrrell	3,545	2,011	15	5	4.23	2.49
Union	29,921	9,176	40	8	1.34	0.87
Vance	16,000	13,961	53	35	3.31	2.51
Wake	72,728	36,816	260	110	3.58	2.99
Warren	8,036	15,109	0	0	0	0
Washington	6,857	5,466	0	0	0	0
Watauga	17,756	358	0	0	0	0
Wayne	33,027	25,301	97	33	2.94	1.30
Wilkes	40,177	2,826	56	4	2.41	1.42
Wilson	29,152	21,067	127	41	4.63	1.95
Yadkin	19,482	1,175	0	0	0	0
Yancey	17,044	158	0	0	0	0
Totals	2,588,049	983,574	7,036	1,760		

As great as is the need for expansion of hospital services for Negroes in North Carolina, there will be some encouragement gained from the fact that in sixty-one counties there are 1,760 hospital beds—ranging from one each in two counties to 279 in one county, and 164 each in two other counties. These facts, hopeful as they are, will help stimulate other counties and communities to provide hospital beds for their Negro people. Also encourage raising the total number of hospital beds from 1,760 to from 3,500 to 4,000 for the million Negroes in the state.

III. NEGROES NEED EXPANDED HEALTH INSURANCE PROGRAM

One of the ideas advanced by the "Hospital and Medical Care Commission" is:

More Doctors
More Hospitals
More Insurance

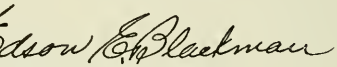
It is probably true that Negroes, for reasons which are well understood, for many years have used more widely than other people various types of commercial and fraternal insurance to help them in serious sickness and in death. For many of these organizations are "Burial Associations" intended to provide respectable funerals and the actual interment of the deceased. It is also probably true that even those with the very lowest incomes have been forced to pay an exorbitant part of their small weekly or monthly wages in order to secure the protection they sorely needed for sickness and funerals. However, while the cost has been high in many instances there was nothing to do but "to pay" the charges—and the *benefits* have been a relief and a genuine satisfaction to thousands who had no other way to provide for themselves and their loved ones, thus assuring at least minimum comforts, medical and hospital service, and when the end comes, a respectable funeral.

The program proposed by the Governor, the State Medical Society, and this Commission will prove to be a real blessing to thousands upon thousands of Negroes, give them courage and determination to lift themselves gradually but surely out of a status of making a bare living into higher income groups, who can and will support themselves in all their needs, and, further will become contributors to the support of their various communities and the State.

For Negroes, as well as for all other people in North Carolina, adoption by the state of the program to provide:

More Doctors
More Hospitals
More Insurance

such as is proposed by the Hospital and Medical Care Commission will, according to the old adage, make them and us "healthy, wealthy and wise." Then, the Governor's declaration: "The ultimate purpose of this program should be that no person in North Carolina shall lack adequate hospital care or medical treatment by reason of poverty or low income," will become a reality in North Carolina.



EDSON E. BLACKMAN
Chairman of the Committee on
Special Needs of Our Negro Population

MENTAL HEALTH
IN NORTH CAROLINA

REPORT OF THE COMMITTEE
ON MENTAL HEALTH PROBLEMS

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THE COMMITTEE
ON MENTAL HEALTH PROBLEMS

James W. Vernon, M.D., Morganton
Mrs. R. J. Reynolds, Winston-Salem
D. Hiden Ramsey, Asheville
M. H. Greenhill, M.D., Durham
Paul Bissette, Wilson
John W. Umstead, Chapel Hill
W. G. Clark, Tarboro
Mrs. Frances Hill Fox, Durham
Judge S. J. Ervin, Morganton

COMMITTEE ON MENTAL HYGIENE AND HOSPITALIZATION

To the North Carolina Hospital and Medical Care Commission:

A sub-committee of the Hospital and Medical Care Commission gave special consideration to the State's problems in respect to mental hygiene and mental hospitalization and made two very concrete recommendations in this field, namely:

First, that adequate provision be made for thorough instruction in psychiatry in the proposed Four-Year Medical School at the University of North Carolina;

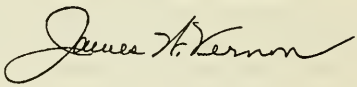
Second, that a psychiatric department be established in the proposed State University Hospital at Chapel Hill.

In common with the nation as a whole, North Carolina is scantily supplied with physicians sufficiently trained in psychiatry to minister to the multitude suffering from mental disorders and maladjustments. The small medical staffs at the several hospitals of the State devoted to the care of the mentally ill are simply overwhelmed by the sheer number of patients committed to their charge. They have no time for research in the treatment of mental diseases. In fact, they are taxed to the uttermost in providing custodial care for the State's insane and in treating the immediate physical ailments of their patients.

Complete instruction in the Four-Year Medical School at the State University in modern methods of diagnosing and treating mental disorders and maladjustments would be a boon to North Carolina. The faculty providing such instruction would furnish the leadership in psychiatry so sorely needed both in the State and in the nation. Experiment and research in the field of mental diseases would be greatly encouraged and enlarged. Youth would be inspired to enter the most undermanned branch of medicine. A competent personnel would be trained to serve the needs of the institutions and population of

the State in psychiatric matters. Under the guidance of the unit teaching psychiatry in the Medical School, mental hygiene clinics could be established in suitable places throughout the State, the relationship between mental sickness and crime in North Carolina could be adequately investigated, and procedures for the mental examinations of persons charged with crime and suspected of insanity could be devised and put in operation. General practitioners could be more adequately equipped to meet the needs of their patients by short clinics and courses of instruction in the field of psychiatry at convenient seasons in the Four-Year Medical School.

The recommendation that a psychiatric department should be established in the proposed State University Hospital at Chapel Hill goes hand in glove with the proposal that provision should be made for thorough instruction in psychiatry in the Four-Year Medical School. In the first place, such a department would be absolutely necessary to enable the faculty of the Medical School to give the necessary clinical instruction to the students taking the courses in psychiatry. In addition, such department would furnish facilities for diagnosing and treating mental disturbances in their early stages and for experimental activity in new methods of mental therapy. Most important of all would undoubtedly result in many persons being saved from long periods of mental sickness in other institutions of the State.



JAMES W. VERNON
Chairman

Dr. Greenhill's Survey:

In connection with this report of our committee we are appending and commending to the careful study of all concerned a quite remarkable "Special Report on Mental Health and Hospitalization in North Carolina," by Dr. Maurice H. Greenhill of the Department of Neuropsychiatry of Duke University. While received too late for consideration by our committee the recommendations he makes should have the careful consideration of the General Assembly and all persons interested in the grave problems treated in this survey.

The information contained in this study has been gathered by Dr. Greenhill from his prolonged experience in this field, including Psychiatric Consultant for the North Carolina State Board of Charities and Public Welfare, Psychiatric Advisor to the State Division of Vocational Rehabilitation, Visiting Associate Professor of Mental Health in the School of Public Health at the University of North Carolina, Associate Professor of Neuropsychiatry and Acting Director of the Department of Neuropsychiatry at the Duke University School of Medicine, Director of the Mental Hygiene Clinic of Raleigh and Duke Rehabilitation Clinic, and Consultant in Psychomatic Medicine for the Southeastern United States.

Duke University
DURHAM
NORTH CAROLINA

School of Medicine
Department of Neuropsychiatry

To the Hospital and
Medical Care Commission:

The mental health problem in North Carolina is a grave one. In a study some years ago North Carolina ranked forty-seventh among the states in the quality of its medical care for mentally ill patients in its hospitals. Yet according to the Thompson report ("A Study of Mental Health in North Carolina," 1937), only 3% of the expenditures from the North Carolina General Fund went to the care of the mentally ill. All of this applies to *state institutional care* which means that North Carolina has not taken seriously enough its responsibility for its citizens with various types of insanity.

This, however, is only a very small part of the problem. It is common knowledge to every physician that the number of patients who suffer from insanity comprise a small group of the total number who are victims of mental illness. This proportion is estimated at 2%, therefore 98% of all individuals who have mental illnesses have no provisions whatsoever made for them for their care by the State. Because many individuals with insanity are chronic cases, the cost of care for this type of disorder is indeed high, and both the obvious need for the permanent care of such individuals and the high cost of their care has focused the attention of the State upon this particular problem.

There is, however, a still greater problem related to the care of the citizens of the State with mental illnesses. This is *the problem of those countless numbers who are involved in psychiatric illnesses which do not necessitate their commitment to a state institution but which constitute a sizeable proportion of the practice of the average physician in the state.* It has been estimated for

many years by many authorities that 40 to 70% of the average physician's practice is devoted to the diagnosis and treatment of disorders at least partly psychiatric in nature. The cost of such treatment is high in terms of actual cost to the patient, cost of time of medical personnel, cost in time in absence from and loss of employment, and general cost to many public institutions including social service agencies, courts, churches, and correctional institutions. This problem spreads even further when it is realized that *the families* of these individuals suffering from the minor psychiatric disorders also become involved in the problem in terms of suffering and decreased work-efficiency.

The 98% who suffer from mental disorders not listed among the insanities have such psychiatric illnesses as psychoneuroses, psychomatic disorders, and personality disorders. In the main it is these disturbances which constitute half the average physician's practice. An individual's income does not prevent him from having one of these illnesses. It may safely be stated that, as in all medical disease, there is a large proportion of patients who are indigent, so among the 98% of individuals with mental disorders but do not need confinement in a state institution for the insane, there are many who are unable to finance the care of their health.

Certain facts may bring into sharper focus the importance of the problem of mental illness in North Carolina. These may be divided for the purposes of clarity into two sections, (1), the needs of North Carolina, and (2), possible solutions for these needs.

FACTS PERTAINING TO MENTAL HEALTH NEEDS IN NORTH CAROLINA

(a) The scope of mental illness in North Carolina:

Mental disorder is made up of the following types of illnesses: Psychoses or the insanities (2%), psychoneuroses, psychosomatic disorders, and personality disorders. The number of individuals in North Carolina who suffer from insanity is known approximately and is made up of those patients in the state institutions, those who have been discharged from these institutions but still have some degree of insanity, and those awaiting admission to these institutions. The problems related to this group of patients are now the responsibility of the State Hospitals Board of Control.

Who should take the responsibility for the other 98% of mentally ill patients who are indigent? It is hoped that the Governor's Medical Care Program will help to handle this enormous problem. It is impossible at the present time to know the actual number of individuals in the State who have psychoneuroses, psychosomatic disorders, and personality problems. The number treated in the few existing psychiatric clinics in the State does not represent the total number under treatment since the average physician always has some under treatment, nor does it represent the need of other individuals for psychiatric treatment who do not receive it. As a sampling of what the need is, it is found that of 97,446 patients seen at Duke Hospital in 1943, 8,283 or 8½% had a psychiatric diagnosis on their hospital records. It may then be estimated that 8.5% of all the patients diagnosed and treated under the proposed North Carolina Medical Care Program will be suffering from some type of mental illness with or without other medical disorders.

Experience and investigation from the literature tells us that this figure of 8½% is indeed small. The difference in part is accounted for by the fact many individuals with medical and surgical disease have emotional symptoms which demand attention and influence healing processes and which have to be treated by a physician although he may not put down a psychiatric diagnosis in the record. This type of problem is called "psychosomatic medicine."

It must be noted that the 8½% of all medical patients who have psychiatric diagnosis is a far larger percentage than many medical problems such as tuberculosis, which are receiving considerable attention in the Medical Care Program.

It follows that of the total population of North Carolina there will be in the course of its lifetime approximately 250,000 individuals upon whom a psychiatric diagnosis will be made. Who is going to take care of the indigents in this group? The number above this who will have some type of emotional problem which a physician will have to handle and upon whom psychiatric diagnosis will never be made, is indeed staggering. Proper facilities for handling this last group in the way of 1) psychiatric education for the medical students who will become the doctors of the State, 2) for the training of the specialists in this field, and 3) for the promotion of psychiatric clinics—these will go far in improving quality of medical care and toward eventually reducing its cost.

(b) The cost of mental illness in North Carolina:

It is well known that the cost of care for a patient with a psychiatric disorder is higher than for any other medical illness. The cost for the care of the insane is known to the Legislature, and the proposed cost which will be necessary to raise the level of the care of the insane person is pointed out by the State Hospitals Board of Control. It is a little more difficult to estimate the cost of care for the other mental illnesses besides the insane. However, under uninformed medical practices, the psychoneurotic goes from physician to physician, has innumerable laboratory tests needlessly done in order to rule out serious medical or surgical disease before the diagnosis of psychoneurosis is made. All of this could be avoided by concentration upon the problem, by proper medical education, and by the setting up of more psychiatric clinics.

As an example of the unnecessary expenses to which individuals with psychiatric illnesses are put, the following study might be cited: Of 100 women who had been diagnosed by one or more physicians as having a purely menopausal disorder but who turned out to have psychoneuroses, it was found that the average cost to each one of these patients prior to the time that the correct diagnosis was made, was $225.00. This amount went for physical examination, x-rays, and injections of glandular products to counteract the menopause which was totally unnecessary since many of these patients were not in menopause nor were they suffering from the effects of menopause. There will necessarily have to be an orientation to mental hygiene in the new North Carolina program to prevent such wastage of money and such injustices to the individual patient.

(c) The problem of the discharged military man:

This war has placed a tremendous burden upon the tolerance of both military personnel and civilians. It is the opinion of most authorities in mental disease, including those in control of Army and Navy psychiatry, that the proportion of individuals who develop insanity is not appreciably greater in war time than in peace time, but that other types of mental illness have increased tremendously. For the nation as a whole it is estimated that by the end of the war there will be 2,000,000 discharged armed forces personnel who will be in need of psychiatric treatment (estimate of the Veterans Administration). In addition there are 1,250,000 men who are induction rejectees on the basis of

psychiatric handicaps who should have treatment. Moreover, there are countless numbers of civilians who will need psychiatric help in readjusting to peacetime conditions, particularly related to relocation in industry. Furthermore the number of families of service men who need similar help is great.

It is estimated that in North Carolina alone there will be by the end of the war 52,000 discharged service men in need of psychiatric treatment and 36,000 induction rejectees who will also need this treatment. *Only 20% of the service men will be eligible for treatment by the Veterans Administration; 80% of the veterans and 100% of the induction rejectees will be the responsibility of the State.* Something has to be done for these men or this sizeable proportion of our manpower will be crippled for a generation and the influence of their psychiatric illnesses on their offspring will be felt in the state for several generations. This is not only a human and moral problem, it is also an economic one.

(d) The present resources for mental hygiene in North Carolina:

The available resources for the care of the mentally ill individual in North Carolina are infinitesimal in proportion to the need. To date most of the emphasis has been placed upon the insane which, as has been stated, comprises only 2% of the mentally ill patients. Those individuals with illnesses of a mental nature lying closer to the whole field of medicine have little opportunity for help and practically no possibility for financial assistance should they come down with a psychiatric disorder. *For example, hospital care associations in the State will not pay for the hospitalization of their policy holders when they file a claim for treatment of any type of psychiatric illness.* The poor suffer particularly and often become dependent upon the public welfare agencies at a tremendous cost to the State in terms of relief expenditures.

At the present time there are only three clinics in North Carolina where these patients can get help. The Department of Neuropsychiatry at Duke Hospital sees approximately 3,000 of these patients per year, the Charlotte Mental Hygiene Clinic 275, and the Mental Hygiene Clinic of Raleigh and Wake County, 130. In the private sanitaria devoted to mental illness there are facilities at any one time for a total throughout the State of 140 patients who can receive treatment for a disorder other than an insanity. In the entire State there are only twenty physicians outside of the State Hospitals who can devote most

of their time to the treatment of these problems. According to present standards each one of these physicians will have to take care of 4,400 veterans and induction rejectees immediately after the war in addition to their civilian psychiatric practice. This is an impossible accomplishment.

POSSIBLE SOLUTIONS FOR THESE NEEDS

(A) The Four-Year Medical School and General Hospital:

It seems apparent that none of the health program of the State can be separated entirely from the proposed Medical Care Plan. Therefore it will be necessary to coordinate the activities of the State Hospitals for the Insane with the proposed Four-Year Medical School at the University of North Carolina and with whatever mental hygiene program might be set up for the State as a whole in terms of medical care. The medical student in training at the proposed medical school will have to have psychiatry as an important part of his curriculum if he is to be prepared to meet the enormous mental hygiene need in North Carolina. This can best be carried out in the following ways:

(1) There should be a strong modern Department of Psychiatry at the proposed Four-Year Medical School. This department should consist of a staff of five to ten psychiatrists who have had the highest training possible and the salaries of these should be sufficiently high to attract good men. Facilities should be available for the training of internes and residents for the field of psychiatry so that these men in time will supply with psychiatrists both the medical care hospitals and clinics and the state hospitals for the insane. It should also have facilities to train psychiatric nurses and psychiatric social workers. It should be flexible enough to allow medical internes to rotate through it as part of their interneship training.

(2) This department should be housed either in a wing of the General Hospital at the Four-Year Medical School or in an adjacent building. I know that 60 beds have been proposed for such a unit, but 100 or 120 would be ideal. There should be 60 beds for adult white patients, 20 beds for children, and 20 beds for Negro adult patients. Such a unit should have a good social service department, an occupational therapy department, and a physical therapy

department. It should contain such laboratory space to attract good men for research opportunities. In this unit every type of modern psychiatric treatment should be used, not only for the welfare of the patient but also for teaching purposes. The men in the state hospitals for the insane should have the opportunity of working for a brief period each year in this unit for purposes of stimulation and for education related to innovations in treatment.

(3) Since the above unit is connected with the General Hospital it follows that most of the patients will come from the 98% of individuals with minor psychiatric disorders. It has been the experience of certain other states that acute receiving hospitals for the mentally ill have proved to be the most economical financially for the state and of the most benefit to the individual patient. For this reason there is in existence the Boston Psychopathic Hospital which is operated jointly by the State of Massachusetts and the Harvard Medical School, and the Langley Porter Clinic in San Francisco which functions under the State of California and the University of California Medical School. These hospitals serve both as teaching units such as the one proposed above and as receiving hospitals for the state hospitals for the insane. Under such projects the advantages are that a great amount of teaching material is available, many patients who would otherwise have to be committed are successfully treated without commitment of a permanent nature, and the entire tempo of a receiving unit can be so much greater than that of an enormous state hospital that patients receive modern methods of treatment much more quickly than they would in a large state hospital, making for the eventual recovery of a greater number.

It would seem advisable under the Medical Care Program in this state to use the psychiatric unit of the proposed Four-Year Medical School as a receiving hospital and to establish one other receiving hospital in the state which is set up under a quality similar to that at the proposed medical school. Such a program would decrease the number of patients in the state hospitals for the insane, prevent many patients from becoming permanent wards of the state, and ultimately be a vast financial saving for North Carolina.

(B) County and Community Hospitals and Clinics:

So far the proposals have dealt with the mental health teaching program and handling of the care of the insane. Some of the larger proportion of individuals with minor psychiatric disorders would be cared for in the psychiatric

unit of the General Hospital and in the other receiving hospital. But the problem might scarcely be touched through these measures unless the proposed county and community hospitals under the Medical Care Program are supplied with facilities for the care of the psychoneuroses, psychological disorders associated with medical and surgical disease, and personality problems.

Every county hospital should have a small number of beds (5 to 10) for psychiatric patients. Each one should also have in its out-patient organization a psychiatric clinic. It should, if possible, have one psychiatrist and one psychiatric social worker. If this is impossible because of limited personnel there should be some system whereby the psychiatrists from the receiving units could be available for regular and frequent psychiatric consultation.

Every small community hospital or community clinic under the Medical Care Program should have psychiatric facilities also. These smaller hospitals should have two or three beds at least for psychiatric patients and at these hospitals or clinics there should be held regularly a psychiatric clinic under the direction of psychiatrists from the county hospitals or from the state receiving hospitals. *Unless psychiatric care permeates through the entire state system in this way, North Carolina will be sorely neglecting one of its large problems.*

North Carolina now has the opportunity of not only raising its own standards for the care of the indigent sick, but also of putting itself in the forefront of progress in the solution of one of the great problems of our time, the care of the mentally ill individual. Mental disorder is more prevalent than tuberculosis and poliomyelitis and it has too long been neglected. Its total cost to the State is as great as all other diseases put together yet little attention is paid to it. Now perhaps something may be done.

Maurice H. Greenhill

MAURICE H. GREENHILL, M.D.

"THE SACRED RIGHT OF EVERY CHILD: HEALTH"

from the Inaugural Address of R. Gregg Cherry, Governor of North Carolina, January 4, 1945

A SCHOOL CHILD HEALTH PROGRAM FOR ALL NORTH CAROLINA

By George M. Cooper, M.D.
and Clyde A. Erwin

One of the earliest and most important of all recommendations of the State Hospital and Medical Care Commission had to do with a greatly enlarged program of health work in public schools as advocated by Governor Cherry, the Commission's recommendation reading as follows:

> "We endorse the proposal for a general examination of school children to discover remediable physical defects, such defects to be remedied at public expense in cases where parents are financially unable to pay for such treatment."

There follow herewith specific recommendations and comment from both Dr. George M. Cooper of the State Board of Health and Mr. Clyde A. Erwin, State Superintendent of Public Instruction.

CLARENCE POE, *Chairman*
North Carolina Hospital and
Medical Care Commission.

"THE SACRED RIGHT OF EVERY CHILD"

By Clyde A. Erwin, state superintendent of public instruction

In his Inaugural Address, on January 4, 1945, Governor R. Gregg Cherry said:

"I believe that an adequate medical examination, and care, should be provided for all the children in the State whose parents are not able to provide the same. This program is in no sense intended to be a plan of socialized medicine, but it is my belief that where parents are unable to finance the cost of remedying childhood physical defects, the State should make provision for this remedial work to be done. Only less sacred than the right of a child to obtain an education is his right to get a fair chance of health in his youth. The neglect of youth becomes the burden of age and a grievous loss to the State in earning power."

The great possibilities of a program such as Governor Cherry proposes are clearly indicated by the excellent results which have been achieved under less ambitious efforts in earlier years.

Dr. Cooper, who was the father of school-health work in this State and who secured astonishing results with a minimum staff during his 14 years as director (1917-31), has summarized our past efforts admirably in the first part of this report, and there is no need for me to go into this phase.

In the light of North Carolina's own past experience in this field, however, and of the experience of other states, it seems to me that the following health objectives are now highly desirable and necessary and can be attained during the present Administration:

Basic Recommendations

1. Improvement of the extent and quality of health instruction in the public schools, including such important subjects as nutrition, first-aid and care of the sick, personal hygiene, alcoholism and narcotism, prevention and control of communicable diseases, cleanliness, social hygiene, and safety.

2. Improvement of the environmental conditions of the schools with respect to sanitation, lighting, and handwashing facilities.

3. Extensions of health services, including immunization, medical examinations and follow-ups for the correction of physical defects.

4. Special programs for children who are handicapped because of defective hearing, poor vision, and mental maladjustment.

5. A physical education program for all *children from grades 1 to 12 as contrasted with an athletic program for a few.*

Need for Cherry Plan

The need for Governor Cherry's plan to examine and correct the defects of all school children—at private expense where possible and at public expense where necessary—is plain and urgent.

When the United States entered the war, the

schools promptly met with the requests of the Governor and the Department to make health and physical education compulsory for all boys in the two upper grades.

Almost half of the schools, with the aid of the state and local medical and dental societies, also gave physical examinations to such students, and the percentage of those with some defect was amazing in many cases:

	PERCENT
Dental defects	85
Defective vision	16
Hernia	2
Diseased tonsils	14
Overweight	7
Underweight	16
Heart abnormalities	1.5

A majority of the children examined in our pre-school clinics each year are also found to have some defect.

The percentage of "failures" in the school has been brought down in the last 10 years from 17.1 to 12.7%, but we feel that the wasted expenditure on "repeaters" might be cut another one-third with better enforcement of compulsory attendance and better school health.

As Governor Cherry has said, "There are literally thousands of boys and girls in our schools who are not reaping the full benefits of educational opportunity because they are suffering from physical defects."

Difficulties in Way

The major factors which make progress difficult in health programs for school children are familiar to many, but I want to list a few of them as background for the thinking and planning of our leaders.

1. There is an acute shortage of teachers who are adequately trained in health education. The colleges are also short on personnel to train them.

2. The State Department has only one man available from State funds to supervise and advise with local school officials in regard to health education, safety, and physical education.*

3. The local pressure on school administrators to continue offering all the traditional subjects makes it difficult to get health and physical education into the curriculum of small schools with present teacher allotments.

4. Health service to the schools is often the last item on the list of essential services of a local Health Department. One reason is that many funds to these departments are dependent upon the services rendered, such as venereal disease treatment or maternity and infant care. Another is that funds are not available either locally or from the State to carry on an adequate corrective program in the schools.

5. Many of our small schools do not have indoor toilet facilities, and the present sanitary laws are either not adequate or not enforced.

State-Local Cooperation

In addition to the state-wide program suggested in the early part of this report, the Department would like to suggest for legislative

* The School-Health Coordinating Service, a staff financed by State, Federal, and Rockefeller funds, also conducts an experimental program in about three counties each year, but this leaves 97 other counties under the supervision of one health educator.

consideration two other important possibilities on a State-Local basis:

1. To amend the School Machinery Act so as to permit any city or county administrative unit to employ personnel for health instruction, health service, and physical education, in the same way that the local units are now permitted to hire extra teachers for vocational subjects. (Such applications would require the customary showing of necessity and approval of the State Superintendent, and the cost would be paid out of monies which come to the county school fund, by law, from fines, forfeitures, penalties, dog taxes, poll taxes, and/or regular tax sources.)

2. It would also be much easier to get city and county administrative units to provide adequate health programs if the State would match the local funds as it now does in the case of vocational subjects. (Virginia now does this as to the employment of doctors, nurses, and teachers of health and physical education.)

CLYDE A. ERWIN

A SCHOOL CHILD HEALTH PROGRAM

By George M. Cooper, M.D., North Carolina State Board of Health

Everyone interested in bettering North Carolina health conditions should rejoice in Governor Cherry's superb advocacy of a greatly enlarged and adequately supported health program for North Carolina school children.

In view of this advocacy it should be perhaps equally helpful 1) to look back at what has been done in a day of relatively small things and small support and then 2) look forward to the vaster possibilities of a really well-rounded child health program for North Carolina. Historically this movement goes back to the inaugural address of the late Governor T. W. Bickett in 1917 when he declared:

> "I have no genius for destruction. Sense and poetry agree that a man must follow his natural bent. It results that the activities of this administration must be exerted along constructive lines. If there be a man in North Carolina who desires to drain a swamp or terrace a hillside; if there be a farmer who is struggling to escape from the crop lien's deadly clutch; if there be a tenant who hungers for a vine and fig tree he may call his own, I want all such to know that the Governor of the State will count it honor and joy to rise up at midnight and lend a helping hand."

And then coming especially to public health, he said:

> "If there be physicians who, with that divine self-forgetfulness that is the birthmark of their calling, are willing to trace Disease to its most hidden lair, and plant the banners of Life in the very strongholds of Death, I want them to know that the State sees a new salvation in their sacrificial labors, and stands ready to clothe them with all needful authority, and place an unlimited armamentarium at their command."

One of the measures Governor Bickett constantly advocated was medical examination of school children, of which he said:

> "Every child has a natural right to have any mental or physical defect corrected, if it be in the power of medical or surgical skill. *The incidental fact that the parents may not be able to pay for the necessary treatment in no way affects the rights of the child.* We cannot claim to maintain an intelligent, much less a Christian civilization, if a child be allowed to stagger through life under the handicap of a mental or physical infirmity for the want of a few dollars. Indeed, it is an economical blunder for society to permit an adult to become a mental or physical derelict for want of proper surgical or medical treatment. It is cheaper to correct these infirmities than to pay for the upkeep of these derelicts in charitable institutions."

In 1917 this writer as State Medical Inspector of School Children, with the aid and cooperation of Dr. W. S. Rankin, Secretary of the State Board of Health, and Hon. J. Y. Joyner,

State Superintendent of Public Instruction, visited and participated in county institutes conducted for two weeks at a time representing 65 counties in North Carolina. Practically every teacher in those counties was present at the time of this visit. It was learned directly from the teachers that more than 75 percent of the teachers had taught the previous year in schools including those in towns and cities in this percentage without any sanitary facilities whatsoever. At that time the State Board of Health was waging an intensive fight for eradicative typhoid fever, hookworm disease and other diseases due to insanitation. A strenuous effort was then inaugurated to provide sanitary facilities in all the schools together with a screening examination by teachers to locate children with remediable defects, a later examination to be followed by agents of the State Board of Health working in counties on a circuit basis. A visit and inspection was made by competent nurses specially trained for the business at least every three years. Following the inauguration of this program from 1917 until 1935 when the plan was discontinued, the writer worked out a plan utilizing appropriations made by the Legislature directly to the State Board of Health on the urge of Governor Bickett, to follow up the findings of the nurses and the local part time county physicians who frequently rendered aid in this program. There were very few whole time health departments at that time in the State. The writer worked out a twofold program.

The Dental Program

First, was the *Dental Program* which was submitted to the North Carolina Dental Society on June 18, 1918, and unanimously endorsed. Following this meeting, six young dentists were employed, the first one beginning his work in Nash County on July 10, 1918. Each one was assigned to a separate county. He was fully equipped with a portable outfit and assigned to work in the schools for school children, regardless of classification, between the ages of 6 and 13 years. The purpose was to teach oral hygiene as well as to do repair work as an educational demonstration. Efforts had been made on an experimental basis running back into 1917 to establish the practicability of such a plan. A summary of the work done by these dentists in what was designated as "free dental clinics for school children" was published in *The Health Bulletin* for April, 1922. Up to that time nearly 70,000 children had been given free dental treatment in the five years embraced, 500,000 children had been examined by teachers searching for defects, and 240,128 children had been examined by school nurses, physicians and dentists. From that day to the present, there have never been fewer than a half dozen dentists employed on the State Board of Health staff, continually doing work for the school children in every section of North Carolina. A number of permanent dental clinics have been established, (for example, here in Raleigh), and a permanent whole time dentist has been employed for many years. No dentist has ever been foolish enough to oppose this program, as it is a constant source of recruiting of patients who need treatment and who are able to pay for it for every dentist practicing in the State. It has been a godsend for more than a million school children in these 26 years since the work was inaugurated.

The Medical and Surgical Program

A companion piece to the provision for dental work was what we called *The Medical and Surgical Division.* Following the work of the nurses who in turn had followed the screening process of the teachers in 86 of our 100 counties, a program of tonsil and adenoid clinics was inaugurated. This followed an effort for two years, 1917, 1918 and 1919, to try to get the specialists in the state to take care of these needs. It was utterly impossible to do so without organized effort. Here again the approval of the Department of Eye, Ear, Nose and Throat of the State Medical Society was secured in 1918 and these tonsil clinics, (called "tonsil clubs" at the time), were inaugurated in 1919 following experimental clinics in three or four counties. To make a long story short, these clinic facilities were set up in schoolhouses, beginning immediately on the close of school along in May, ending in September, and every summer from 1919 to 1931 inclusive, from 2,000 to 2,300 children were operated on successfully for the removal of tonsils and adenoids.

A total of 23,211 children received operations with only two deaths in the whole series, one death occurring in Moore County in a child who was operated on under private auspices having been refused as a bad risk by the clinic physicians. The other child in Alleghany County went in swimming the week following the operation contrary to advice and received a pneumonic infection. The mortality records have never been approached anywhere in the United States.

A group of competent graduate nurses were in charge of this program under the specific direction of the writer during all of the first years of the work. The best operators in the State were secured for the operations. They were paid an adequate per diem from small funds collected from some of the patients. These funds also paid for additional nurses, for the equipment and supplies, a special truck being made to order and complete equipment of the very best including cots, blankets, sheets, etc. The children were grouped in sections of 25 carefully selected according to their grave needs for such operations and of the safety with which it could be performed. They were kept over every night and sent home next morning.

As stated in the beginning of this article, this work was on a demonstration basis. It introduced good operators of established practice here in North Carolina to the people in their own sections and it has meant prosperity ever since to this group of specialists besides the thousands upon thousands of children who secured better health as a result.

Five Features of a Future Program

In view of this writer's experience in the practice of medicine for nearly ten years and the following thirty years experience in an intensive study of this whole field, the following outline of procedures necessary for success may be set forth with faith and confidence in the effectiveness of such a program:

First, an appropriation by the State Legislature directly to the North Carolina State Board of Health is the first requisite, the appropriation to be earmarked and specifically provided for this purpose under the directorship of a physician who must be a crusader for the public in-

terest and who is willing to fight for the underprivileged children in North Carolina, but at the same time who is a qualified, trained physician and who has common sense and initiative and the ability to do creative thinking as occasion demands.

Second, the cooperation between the State Board of Health and the State Department of Education must be re-established on the basis that it was so happily and satisfactorily carried out in those years between 1917 and 1931 in which 1) the Department of Education assumed responsibility for the teaching in the classroom of all public health subjects (just as they would mathematics and English) and 2) in which the State Board of Health has full and complete jurisdiction over the physical defects found in such school children and in all matters of epidemiology and disease control.

Third, it is absolutely necessary for all local principals and teachers of all the schools to be in wholehearted sympathy with this program. It is hardly necessary to say that a strict enforcement of the attendance law is necessary and sympathetic cooperation of all classroom teachers is an absolute necessity.

Fourth, a strict system of annual inspection of every school child enrolled in the schools of every county must be provided under the leadership of the State Board of Health cooperating with the local health departments in each city and county which must provide the personnel to do the examinations following the screening process first done by the teachers under the guidance of the State and local health departments.

Fifth, it is utterly useless to make these examinations, to do all this teaching, to make all the efforts that so-called public health education in the school room or in the departments of health require unless organized plans for followup are provided. These plans must be submitted and followed through by the State Board of Health and the director selected to carry on this program. A cooperative plan with practicing physicians including every specialty group and the general practitioners known as family doctors is necessary. This can be very well arranged. Four imperative needs are these:

1. It is an absolute necessity that the State own and operate and control a Four-Year Medical School in order to assure the proper distribution of physicians in the State.

2. It is equally as necessary to have hospital facilities and medical centers in every section of the State easily available to these children and their parents.

3. Provision must be made to take care of the big majority of the children who cannot pay top prices for medical and surgical work but who can pay something, and of course for the lesser group who cannot provide anything that costs money for themselves.

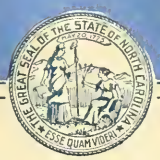
4. Defects constantly located will run the whole scale of human diseases encountered in this climate, from pediculosis to one or the other of the many hundreds of forms of eczema. Nutritional deficiencies will be rampant. Intestinal diseases are still highly prevalent in most of the rural sections of the State. A sympathetic and cooperating medical profession is an abso-

lute necessity, together with the provision of hospital facilities to cope with the situation.

The program can be put on a practical basis and carried through with promise of 100 per-cent success just as our tonsil clinics from 1919 to 1931 were carried on and just as our dental clinics have been carried on successfully for 26 years. The Legislature can provide the money but the leadership must be provided in the Health and Education Departments, including State and local and professional cooperation by physicians, dentists and hospital managers which must be forthcoming.

How Much Would It Cost?

The cost of such a program as is here set forth would depend entirely on what the people wanted done for their children. A conservative estimate of the cost of setting up the administrative machinery and getting the program underway for the first two years, if placed exclusively in the hands of the State Board of Health, would be about $300,000 a year. This estimate is based on the very successful program of diagnosis and treatment of crippled children carried on by the State Board of Health for the past eight years with the cooperation of every one of the orthopedic surgeons practicing in North Carolina.



"WE CAN DO SO MUCH FOR THE HEALTH OF SO MANY, AND AT SO LITTLE COST"

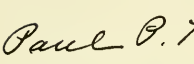
REPORT OF THE COMMITTEE ON A FOUR-YEAR MEDICAL SCHOOL AND CENTRAL HOSPITAL

REPORT ON THE PROPOSED FOUR-YEAR MEDICAL SCHOOL AND CENTRAL HOSPITAL FOR NORTH CAROLINA

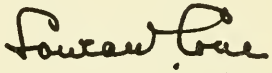
To the North Carolina Hospital and Medical Care Commission:

The Committee on the Four-Year Medical School and Central Hospital has worked for nine months studying medical schools in other states, surveying the needs of North Carolina and formulating our final recommendations. The minutest details of the many phases of this vast problem have been studied and weighed most thoroughly.

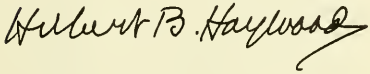
We believe that our plans and recommendations are sound. We believe that our estimates of the non-recurring construction costs and the operating costs are conservative and reasonably accurate. We believe that the people of North Carolina will be surprised to learn that we can do so much for the health of so many, and at so little cost.



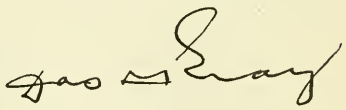
Paul P. McCain, M.D., Chairman, Sanatorium



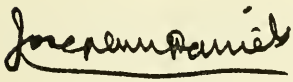
Laura Weil Cone, Greensboro



Hubert B. Haywood, M.D., Raleigh

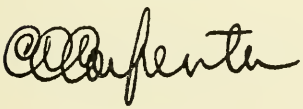


James A. Gray, Winston-Salem

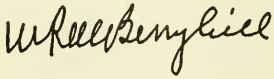


Josephus Daniels, Raleigh

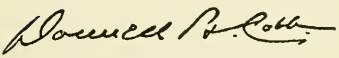
Alexander Webb, Raleigh



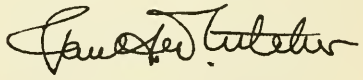
Dean C. C. Carpenter,
Bowman Gray School of Medicine



Dean W. R. Berryhill,
University of North Carolina Medical School



Donnell Cobb, M.D., Goldsboro



Paul F. Whitaker, M.D., Kinston

Dean W. C. Davison,
Duke University Medical School

RECOMMENDATIONS

To the North Carolina Hospital and Medical Care Commission

The Committee on the Four-Year Medical School and Hospital Facilities for the University has, through two sub-committees, made a careful study of the number and distribution of medical personnel in the State and of representative state-supported schools of medicine in the Middle West and the South. In addition, it has had access to the findings and reports of a previous Commission making a somewhat similar study in 1937.

The findings of this Committee and of other Committees of this Commission show clearly the need for more medical personnel of all types — physicians, nurses, public health nurses, physicians in public health, medical technicians, health educators, physiotherapists, and hospital administrators — for the state as a whole and especially for the less populous rural and small town communities. It is estimated that there is a need now for 1,500 additional physicians, well distributed, in the State in order to lower our physician-population ratio to 1/1000, generally considered desirable for the maintenance of the proper safeguards for the health of the population.

In a study of this problem by a sub-committee of the Committee on Rural Hospitals and Rural Medical Care, it is stated by Dr. W. C. Davison[1] that 76 new physicians started practice in North Carolina each year for the period 1936 to 1942 inclusive, and that at least 75 more physicians are necessary each year to reach the desired physician-population ratio in a period of fifteen years. In order to insure this increased number of new physicians each year, there is a need for from 87 to 132 additional North Carolina medical students annually, depending on the proportion eventually practicing in the State.

North Carolina is faced with two alternatives in securing an adequate number of physicians and other medical personnel: (1) To provide means and facilities for training its own residents who desire to study medicine; or, (2) to attempt to import physicians from without the State. The Committee feels that the first alternative is a sounder and wiser policy. To quote Dr. W. C. Davison, "The South will not get its physicians by migration. The students should be Southern, and to get country doctors it must be possible for students from the rural counties to study medicine."

It is true that the economic factor and hospital facilities play important roles in the number and distribution of physicians in any state. It is also true that because of these factors and that of climate some states in which there are no medical schools

[1]During period 1936-42 fifty-six physicians died annually. According to Dr. W. D. James, Secretary Board Medical Examiners 1938-44, eighty or more physicians are necessary each year to replace losses in profession from all causes.

have a better physician-population ratio than North Carolina; yet, in general,[2] "local medical schools have an important influence on the number of graduates who practice in the community and state," and those states in which there are greater facilities for medical training have more medical personnel available to serve the population.

The two excellent privately endowed four-year medical schools in North Carolina are rendering a great service in medical education. The Duke University School, graduating doctors for approximately twelve years, has admitted annually only about 25 per cent of each class from state residents —15 to 23 students. The remaining 75 per cent of its students, because of its excellent national reputation, come from many states. According to the records of the State Board of Medical Examiners for the past five years, an average of 15 graduates of the Duke Medical School were annually licensed to practice in North Carolina.

The Bowman Gray School of Wake Forest College has for many years shared with the University of North Carolina the major responsibility for training North Carolina residents in medicine. It has just graduated its second class. During the five years ending in 1943 an average of 20 physicians annually who had taken their first two years at this institution were licensed to practice in North Carolina. In the future it is reasonable to expect that this number will be at least doubled.

[2]Dr. W. C. Davison—Journal Assoc. Am. Med. Colleges, March 1943.

The State is greatly indebted to these two institutions and justly proud of their accomplishments. As endowed schools of medicine they have other affiliations and responsibilities and cannot be expected to have as their primary concern the training of medical personnel for the State.

This Committee feels very strongly that there is an obligation and an opportunity for the state to provide facilities for professional education for its citizens in all branches of medicine, as it does in law, pharmacy, various types of engineering, business, agriculture and teaching. There is ample precedent in the State for the development of professional training in endowed and state-supported institutions in the face of demonstrated need. The presence of three law schools at Duke, Wake Forest and the University has been of great value to each other, the legal profession and the State. The two engineering schools at State College and at Duke are mutually helpful to each other and the State.

Because of the urgent need for training more North Carolina men and women in all branches of Medicine, it is recommended that the State provide adequate financial resources to expand the present two-year Medical School of the University which, with the School of Public Health, would serve as a foundation for developing a State University Center for Medical Education in its broad sense. The two-year school at the University has been for over fifty years the largest single source of sup-

ply for physicians in the State, educating in part approximately one-fourth of the total.

Such a development, in co-operation with and supplementing the two endowed medical schools, would, in a short time, begin to supply the State with the necessary well-trained medical personnel, provided (A) at the same time the program for expansion and better distribution of hospital and diagnostic facilities goes forward; and (B) means are made available through loan funds or scholarships to aid worthy students from rural areas and small communities to finance their medical training.

Not only is a medical center on a state university basis necessary to increase the production of doctors and other medical workers, but its influence in maintaining and elevating the standards of medical and hospital service is equally as valuable in a program designed to give better medical care to the people of North Carolina. It would supplement the efforts of the other two schools in this field and make available consultation services in the medical specialties and more technical branches such as X-ray, pathology and general laboratory for physicians and hospitals in the smaller and more medically isolated communities. It would offer a continuous program of postgraduate training for practicing physicians in the community hospitals and at the center. It is believed that the tangible returns on these two services alone in terms of elevating the quality of medical care throughout the State would more than compensate for the cost of operation.

In the light of the facts herein set forth and on the advice of competent medical educators, the Committee submits the following recommendations:

1. That the present two-year School of Medicine at the University of North Carolina be expanded into a standard four-year medical school.

2. That the completed school and hospital facilities be located on the University campus at Chapel Hill.

3. That a hospital of approximately 600 beds be built to provide clinical facilities for teaching and to aid in serving the hospital and general health needs of the State. It is the feeling of the Committee that there should be facilities for both white and colored patients. In addition to the general hospital ward beds, such an institution should have:

a. a moderate number of rooms for private patients;

b. facilities for psychiatric patients, both bed and ambulatory;

c. facilities for a limited number of tuberculosis cases, surgical and medical;

d. facilities for a large dispensary or outpatient department.

We recommend the following distribution of beds: 400 general ward beds; 60 beds

for psychiatry; 60 beds for tuberculosis; and 70-80 beds for private patients.

4. That at a state university it would be a wise policy to provide the major part of income for the clinical staff from salary rather than from private practice.

5. That every facility and encouragement for postgraduate training for practicing physicians in the State be provided, both through intra and extra-mural courses of clinics and lectures.

6. That a School of Nursing be established and that every effort should be made through co-operation with the Woman's College to encourage more adequate professional education for students of nursing. A program of co-operation between the University School of Nursing and the nursing training schools in the smaller hospitals in the State should be carefully studied with the view of aiding in the elevation of the standards of nursing education in the State.

7. The University has the only School of Pharmacy in the State. Its present physical facilities are inadequate for the increasing demand in its undergraduate program and in the development of postgraduate training. The importance of the pharmacists in any medical service program and the need for the expansion of the Pharmacy School is recognized. The Committee, having heard the proposals of the committee from the Pharmaceutical Association, is wholeheartedly in favor of facilities for medical and pharmaceutical education at the University.

8. The shortage of dentists is acute in this State and facilities are urgently needed for training more personnel in this field. The Committee recommends that a study of this problem be continued and that the possibility of establishing a dental school in the future should be given careful consideration.

9. The Committee recognizes the need for more well-trained Negro physicians in North Carolina and in the South and feels that an opportunity should be provided for more qualified Negro citizens to study Medicine and Dentistry. Careful thought has been given to possible ways of providing educational facilities in Medicine for the Negro race. The Committee recommends that the State of North Carolina join with neighboring Southern States in exploring the possibility of developing a regional medical center for the education of Negroes.

COST ESTIMATES

STATEMENT A

Construction Costs

Hospital

Addition to Medical School

Nurses' Home

Residents' and Internes' Home

Equipment

STATEMENT B

Hospital Operating Costs

STATEMENT C

Four-Year Medical School Budget

Statement A

Estimates of Costs of Construction

Prepared September 13, 1944

1.	Hospital (600 beds @ $4,000)	
	400 General Hospital Ward Beds	$1,600,000
	60 T.B. (Surgical) Beds	240,000
	60 Psychiatric Beds	240,000
	80 Private Beds	320,000
	Total	$2,400,000
2.	Equipment @ $1,000 per bed	600,000
3.	Addition to Medical School	175,000
4.	Nurses' Home (Capacity 350 @ $1,300)	455,000
5.	Equipment (350 @ $100)	35,000
6.	Home for Internes and Residents (Cap. 100)	150,000
7.	Equipment	20,000
	Total	$3,835,000

Note: Provision should be made for the extensions of all services—heat, power, water, sewerage, telephone, for an already overloaded plant, therefore no allocation for these services is added to this project.

Respectfully submitted,

James A. Gray,
W. R. Berryhill,
Donnell B. Cobb,
Committee

Statement B

Hospital Annual Budget Estimates

(81% of 219,000 Patient Days—177,390)

	Amount	Per Patient Day
Estimated Expenditures		
1. Administration	$ 74,702	$ .43
2. Dietary	(276,558)	(1.56)
a. Food	197,087	1.11
b. All Other	79,471	.44
3. House and Property	(201,856)	(1.14)
a. Laundry	44,504	.25
b. Housekeeping	58,808	.33
c. Plant Operation	98,544	.56
4. Professional Services	(440,269)	(2.48)
a. Medical and Surgical	109,670	.62
b. Pharmacy and Drugs	33,378	.19
c. Nursing Services	217,750	1.23
d. X-Ray and Radium	41,325	.23
e. Laboratory	38,146	.21
5. Total Expenditures	$993,385	$5.60
Estimated Receipts		
6. Receipts from Patients	$331,128	$1.87
7. From Other Services	30,000	.17
8. Total Operating Receipts	$361,128	$2.04
Support		
9. Excess Expenditures	$632,257	$3.56
10. If Duke Endowment Contributes $1.00 per day for free days	$ 59,130	.33
11. State Appropriation Needed	$573,127	$3.23
12. If Counties pay $1.00 per free day, State Appropriation Needed	$513,997	$2.90
13. If Counties pay $2.00 per free day, State Appropriation Needed	$454,867	$2.56

Respectfully submitted,

James A. Gray,
W. R. Berryhill,
Donnell B. Cobb,
Committee

Proposed Four-Year Medical School Budget Estimates

Prepared September 5, 1944

Departments of:	*Total*	*Salaries & Wages*	*Supplies & Expense*
Anatomy	$ 26,400	$ 23,900	$ 2,500
Bio-Chemistry	17,150	15,150	2,000
Bacteriology	20,500	17,500	3,000
Pathology	34,000	31,500	2,500
Pharmacology	24,900	21,900	3,000
Physiology	24,200	22,200	2,000
Medicine	67,100	62,600	4,500
Surgery	85,500	81,500	4,000
Obstetrics	27,600	24,000	3,600
Pediatrics	27,600	24,000	3,600
Psychiatry	25,650	23,250	2,400
Library	12,000	7,000	5,000
Medical Illustration	2,500	1,800	700
Administration	15,400	12,600	2,800
Physical Plant Opr. Maintenance	23,964	10,714	(2) 13,250
Total Estimated Expense	$434,464	$379,614	$54,850

Deduct Estimated Receipts	
(1) Students Fees	$ 64,500
Transfer to Hospital	14,000
Endowment and Trust Funds	6,500
Total Estimated Receipts	$ 85,000
Estimated Appropriation	$349,464

(1) Second year of operation—(First year $48,350.)

Basis: Average enrollment for each class, 50, and at rates of $300 for in-state and $450 for out-of-state.

Second year: 170 in-state students at $300 ..... $51,000
30 out-of-state students at $450 13,500

(2) Janitorial Supplies, $500; Electricity, $5,500; Water, $650; Heat, $3,100; Repairs, $2,000; Animal food and expenses, $1,500.

Respectfully submitted,

James A. Gray,
W. R. Berryhill,
Donnell B. Cobb,
Committee

Sub-Committee
To Survey Medical Schools
In Other States

To the Committee on Medical Schools and
Hospital Facilities for the University:

In this report the sub-committee has attempted to present information and impressions received on a survey of four state-supported schools of medicine. The details of the operation of the hospitals associated with the four schools and their relation to the medical care program in the various states are being presented by Dr. William Coppridge's committee.

In carrying out this survey the sub-committee acknowledges with deep gratitude the aid it has received from:

Dr. William Coppridge, who was secretary of the committee appointed by Governor Hoey in 1937 for a similar study and who kindly made available all the data compiled at that time.
Dr. C. C. Carpenter, also a member of Governor Hoey's 1937 commission.
Mr. R. G. Deyton.
Mr. W. D. Carmichael, Jr.

This report containing information and recommendations made on the basis of this and previous surveys is respectfully presented with the hope that it, with the studies being made by several other committees, will be of some value to the commission in its attempt to formulate a long-term program for better medical and hospital service for the citizens of North Carolina.

Mrs. Julius W. Cone
James A. Gray
Paul F. Whitaker, M.D.
Donnell B. Cobb, M.D.
W. R. Berryhill, M.D., *Chairman*

S U M M A R Y

By the Sub-Committee To Survey Medical Schools In Other States

The sub-committee on visiting state-supported schools of medicine in other states has studied the medical school and teaching hospital of the Universities of Michigan, Virginia, Iowa, and the Medical College of Virginia. All of these are first-rate institutions; two, the Universities of Michigan and Iowa, are outstanding among medical schools of this country.

Location

Three of the schools visited are on the campus of their respective universities in relatively small towns (see chart) with a population range from 18,000 (Iowa City) to 35,000 (Ann Arbor). It must be remembered, however, that when these three schools were first founded these towns were much smaller than the present census. The fourth school, the Medical College of Virginia, is a medical center of a large southern city and should more properly be classed as a municipal institution rather than a part of a university.

The Committee sought the advice of authorities of each institution as to the ideal location of a university school of medicine, from the point of view of medical education and of serving the state as a part of a broad program to provide better medical care. Dean Furstenberg, of Michigan, President Hancher and Dean MacEwen of Iowa, President Newcomb, Dean Jordan, and Assistant Dean Mulholland of Virginia, and Dr. W. B. Porter of the Medical College of Virginia all unanimously advised the location of the School at Chapel Hill. They felt from their own experience that close association with the facilities of a university, especially with the graduate school, was very important. Furthermore, it was the distinct impression of the committee that the schools and hospitals located in a university environment have an atmosphere of intangible fineness, quality and character that is not only desirable but essential.

Experience at the institutions located in small towns and at the two endowed North Carolina schools in larger towns show that with modern facilities for travel patients will come to any institution where they receive excellent care.

At Iowa and Michigan, and formerly at Charlottesville, there has been an inadequate supply of clinical material for obstetrical teaching. This deficiency has been overcome by co-operation with lying-in hospitals in larger cities.

The out-patient clinic at Iowa has on an average only the minimum number of daily clinic visits required for an approved teaching hospital by the Council on Medical Education and Hospitals of the American Medical Association; on the other hand, the out-patient departments at the Univer-

sity of Michigan and at Charlottesville are quite adequate.

Size of Teaching Hospital

The total bed capacity of the teaching hospitals of the four institutions varies from 525 (University of Virginia) to 1,400 (University of Michigan). It is the opinion of both Dean Furstenberg at Michigan and Dean MacEwen at Iowa that a teaching hospital should not be too large if the best interests of medical education and medical research are to be served. They suggest 400-600 teaching beds.

In addition to general hospital beds, Michigan has a psychiatric and a tuberculosis wing included in the general hospital. The University of Virginia has similar facilities for mental diseases, but uses a 350-bed tuberculosis sanatorium for teaching purposes which is a separate state institution a few miles from Charlottesville. At Iowa the psychiatric hospital is a separate institution but is on the campus near the School and Hospital, while the tuberculosis sanatorium is nearby.

Each of the hospitals has accommodations for private patients ranging from 70 to 80 beds at the University of Iowa to 155 at the Medical College of Virginia.

Size of the School and of Entering Classes

See chart.

Tuition

See chart.

Budget

The figures given for the budgets at Michigan and Iowa represent, according to the respective Deans, the total amount spent for their schools. At Virginia the budget as given in the table does not include the income to the school—quite considerable—derived from the fees of private patients to clinical staff over and above the salary ceiling. This is estimated to be in excess of $100,000.

At the Medical College of Virginia the budget as given does not include the total operating cost of the School of Medicine since a part of the salaries of the clinical staff is charged to the hospital, and a part to the schools of pharmacy, dentistry, and nursing. We have no basis on which to accurately determine the total budget of this School.

State Appropriations to Schools

See Chart.

Hospital Budget With Income From Patients and State Appropriation

See Chart.

Nursing School

Each of the institutions visited maintains a first-class school of nursing. At all except the Medical College of Virginia the entire expense of maintaining this school is charged to the hospital.

Dentistry

Each of the schools except the University of Virginia has a School of Dentistry.

Salary Scales

See Chart.

WHAT OTHER STATES SPEND TO PROVIDE HO

Institution	Location Population	HOSPITAL							
		Hospital Beds				Out-Patient Department	Budget	Income from Patients	
		Total	Psychiatry	Tuberculosis	Private				
University of Michigan	Ann Arbor 35,000	1437	80	100	90	350—400 average daily visits adequate	3,200,000	1,440,000	1,7
University of Iowa	Iowa City 18,000	1000	60		5%–7%	100 av. daily visits Barely adequate	1,500,000	400,000	1,
University of Virginia	Charlottesville 22,000	525	40	350 (near by)	150	170 average daily visits adequate	758,000	639,685*	
Medical College of Virginia	Richmond 200,000	900			155	300 average daily visits adequate	1,500,000	932,653*	

* Total

PITALS AND MEDICAL CARE FOR THEIR PEOPLE

tate propri- tion	SCHOOL OF MEDICINE							Nurses' School	Dental School
	Size	Entering Class	Tuition	Budget	State Appropri- ation	Salary Scale of Depart- ment Heads	Additional Income Clinical Staff		
,000**	500	125 to 130	R $250 NR 400	585,000 ††100,000 (Research)	432,000	$7,000 to 15,000	Yes (2 men each Dept.)	Yes	Yes
00,000	340	90	R 226 NR 490	550,000	390,000†	6,000 to 10,000	Part of Staff	Yes	Yes
51,671	240 to 260	65	R 310 NR 360	345,000‡‡‡	127,000	5,000 to 10,000 (ceiling of $15,000)x	All	Yes	No
38,951	350 to 360	80	R 325 NR 480	297,000*** (only part)	154,475‡ 201,000‡‡	5,000 to 10,500 (contemplate ceiling of $15,000)	All	Yes	Yes

nues reported by institution; may include more than income pay patients.

** Amount paid by State for charity patients treated in hospital on per diem basis of $6.50.

*** Represents only part of Medical School budget; see detailed report.

† Figure quoted by Dean MacEwen.

†† Figure submitted by R. G. Deyton.

‡ Figure submitted by R. G. Deyton from Virginia State Budget.

‡‡ Figure quoted by President Sauger.

‡‡‡ Does not include income from private patient fees which accrues to clinical department for budgetary use; see report University of Virginia.

x Difference between school salary and ceiling salary represents income from private practice.

R—Residents of State.
NR—Non-residents of State.

Status of Clinical Staff

At all three university schools of medicine the teaching staff in the clinical departments are "geographically full time"; that is, they give their entire time to medical school and hospital duties. The particular systems followed in dealing with the difficult problem of teaching duties and private practice varies with each institution and with individual staff members in each institution. Some receive only nominal salaries from the school and derive almost their entire income from private practice; others receive a larger salary and have less income from private patients. In a few instances clinical men are on strict full time, in which cases the school salaries are higher than for men in the other two groups.

Only one man, Dean MacEwen at Iowa, advocated ideally a strictly full-time salaried teaching staff, but even he admitted that the teaching and public relations value of private patients to the institution were considerable and probably indispensable. He felt, from the standpoint of a medical school administrative officer, that a full-time salaried staff would offer fewer problems. At the other institutions the wisdom of a strictly salaried staff was doubted.

At the Medical College of Virginia, as indicated in the report of that institution, conditions are different because of the location in a large city. Many of the teaching staff are not "geographically full time" but have their offices outside the hospital and are paid no salary.

On the basis of the survey of this committee and on the survey of medical schools, both state-supported and privately endowed, made by a committee in 1937 appointed by Governor Hoey, it is obvious that there is no general uniformity in the details of organization of the medical schools in this country. Each one is an individual institution that is using available financial, personnel, and hospital facilities as best it can. Each has its own goal and individual problems peculiar to its location, local traditions, conditions, and budget. Thus the administrative problems and the method of their solution in a school located in a large city may be entirely different from those of a school in a small town, just as those of a privately endowed school may differ from problems in a school largely state supported.

SURVEYS

OF MEDICAL SCHOOLS
IN OTHER STATES:

1. The University of Michigan
2. The University of Iowa
3. The University of Virginia
4. Medical College of Virginia

UNIVERSITY OF MICHIGAN SCHOOL OF MEDICINE

NUMBER 1 OF A SERIES OF SURVEYS BY THE COMMITTEE ON MEDICAL SCHOOLS

ANN ARBOR—POPULATION 35,000

The University of Michigan School of Medicine is one of the older and more outstanding schools in this country. It has now and has had for many years a great many distinguished men in its faculty.

At present the School is housed in two well-equipped buildings on the University campus some little distance removed from the University Hospital. Dean Furstenberg deplored the present situation and informed the committee that plans have already been drawn to build a new school of medicine building adjoining and connected with the Hospital, as soon as materials are available after the war. He felt that there should be a very close physical as well as spiritual connection between the medical school and the teaching hospital and that wherever possible they should be in the same or adjoining buildings.

He was most emphatic in stating that for the best interests of medical education a University medical school should be located on the University campus and that both the school and its hospital should be an integral part of the University system. From his experience he felt there was no appreciable disadvantage in locating a school of medicine and its teaching hospital in a small community from the standpoint of not having sufficient clinical material. In fact, he favored the small town location. He cautioned—for the best interests of teaching—against a hospital of too many beds for the reason that the staff in the clinical departments might become so overburdened with the responsibilities of caring for patients that their time for teaching and research would be limited. He thought ideally a hospital of 600 to 700 teaching beds would be adequate.

Dean Furstenberg felt that at Ann Arbor there was an adequate number of patients with a wide variety of illnesses both acute and chronic for teaching purposes with the possible exception of obstetrics and acute traumatic surgery. But arrangements have been worked out through affiliation with Detroit hospitals for supplementing the training of medical students, nurses, and interns in these two fields.

Enrollment, Fees, and Budget

The enrollment of the School is approximately 500. Tuition for in-state students is $100 a semester and for out-of-state students $150. The estimated cost of instruction per student per year is $1730. The total annual budget of the School is $545,000, most of which comes from State appropriation to the General University. There is an additional $100,000 available for research, of which $60,000 comes from endowment and $40,000 from temporary grants-in-aid for special research projects.

The Faculty, Salaries and Status

Normally the teaching staff consists of approximately 200 members. All of the preclinical faculty are on full-time salaries. For the clinical staff a rather unique plan has been adopted which allows each department head to receive a somewhat reduced University salary but to supplement this by income from private practice in the Hospital. The remaining members of the clinical departments are on a full-time salary. The Head of the X-ray Department is likewise full-time (salary of $15,000). Some of the professors and department heads receive a University salary of $7,500 but actually have a much larger income from private practice. All the clinical staff are said to be on "geographical full - time"; that is, their work is done entirely in the University Hospital.

The salary scale for the School in general follows the schedule below:

Senior Instructor	$1,700 to $1,800
Assistant Professor	3,500 to 4,000
Associate Professor	4,000 to 6,000
Full Professor	7,000 to 15,000

Dr. Furstenberg in answer to many questions in regard to this arrangement summarized his feeling after many years of studying medical schools and from his experience at Michigan as follows:

Formerly Michigan insisted on a full-time salary for all the clinical staff but found that it was impossible to hold outstanding men on university salaries and could compete neither with other schools which permitted their staff to have private practice nor with the opportunities offered the staff to enter private practice in large cities. The present system has satisfied the department heads and the other staff members allowed to supplement their income but the Dean admitted there was some dissatisfaction among others still on a full-time basis.

Dr. Furstenberg felt rather strongly that men in the clinical branches were better teachers if they spent a part of their time in private practice because it helped them teach both the "art and science" of medicine. He admitted the danger that a valuable teacher may become so engrossed in private practice that he may neglect his University duties, but on the whole he felt that the "gentleman's agreement" between the University Administration and the clinical staff that the University duties must take precedence was seldom violated and that the present system was working better for everyone concerned—the Administration, the staff, the students, and the Hospital—than the discarded full-time system. He called attention to the unhappy experiences at Chicago and Cornell as an argument against full-time clinical staff.

There is the closest co-operation between the University Hospital and the School of Medicine. The clinical staff of the Hospital all hold teaching positions in the School of Medicine and most of their salaries are paid by the Medical School. The Hospital in turn supplies the staff with office space, secretarial and technical help, and these men are permitted to treat private patients

both in their offices and in the private rooms in the Hospital.

The University of Michigan has recently established a fine School of Public Health with the aid of the Kellogg and Rockefeller Foundations. It is housed in splendid new buildings near the Hospital. Its faculty is excellent.

COST OF MEDICAL SCHOOL (INCLUDING DENTAL)

	Buildings	Equipment	Total
Medical	$1,026,837	$ 702,994	$1,729,831
Dental	598,254	372,125	970,379
Totals	$1,625,091	$1,075,119	$2,700,210

NOTE: The Dental School is tied in with the Kellogg Institute and may not be true cost.

CAPACITY OF MEDICAL SCHOOL

Class of — 125 to 130.
Average capacity approximately—500.

COST OF OPERATING MEDICAL SCHOOL 1942-43

Salaries and Wages		$503,964
Other		81,086
Total Costs		$585,050
Less Receipts—		
Tuition — Regular	$148,333	
Tuition — Summer Ses.	3,380	
Laboratory Fees	1,998	
Total Receipts		$153,711
State Appropriation		$431,339

IMPRESSIONS

I. The School of Medicine at the University of Michigan is one of the outstanding schools. Its faculty is distinguished for teaching and research. It has very fine traditions, many of which serve as an inspiration and some, unfortunately, as is the case in many older institutions, may be proving a handicap in present-day planning and organization.

II. The School is undoubtedly handicapped by the present physical plant—both in the matter of the two unconnected buildings and the distance of both from the Hospital. Plans are already under way for correcting this situation at the end of the war, which should make for a decided improvement in organization and effective coordinated work.

III. The salary scale is higher than that in many southern state university medical schools but even so the salaries of the clinical staff must be supplemented by income from private practice in order to hold the good men.

IV. One might question the wisdom of allowing only one assistant in each clinical department to join the department head in private practice. It would seem wiser for the morale of the staff not to discriminate against others who might wish to have a limited private practice.

UNIVERSITY OF IOWA SCHOOL OF MEDICINE

Number 2 Of A Series Of Surveys By the Committee On Medical Schools

IOWA CITY—POPULATION 18,000

The Medical School of the University of Iowa is housed in a relatively new well-equipped and well-planned building on the University campus, adjoining the University General Hospital with which it is connected and is across the street from the nurses' home, the children's hospital, and the psychiatric hospital, all units of the State University Hospital system. It is a school of national reputation and with an excellent faculty.

Enrollment

Entering classes are limited to 90 students and preference is given to state residents. The present enrollment is approximately 400. The tuition for residents is $113 a semester and $245 a semester for non-residents.

The total budget of the School is $550,000. Of this amount between $380,000 and $390,000, according to Dean MacEwen, comes from state appropriation to the General University; a small amount — not specified — from endowment; and something over $100,000 is earned income from professional fees of members of the clinical staff on full salary—which accrues to the budgets of the various clinical departments.

Salary scale:

Assistant Professor	$3,000 to $ 4,500
Associate Professor	4,500 to 8,000
Full Professor	6,000 to 10,000

It is felt that the salary scale is too low to attract and hold the most capable and promising men and it is planned to raise the level as soon as possible. Dr. MacEwen would like ideally to put all the heads of the clinical departments on a full-time salary of from $10,000 to $12,000, and allow those who wished to do limited private practice for its value in teaching and public relations in the state.

At present all the members of the clinical departments are full time in the hospital and most of them are on full-time salary from the School of Medicine. However, some of the department heads are permitted to have a considerable amount of private practice and receive only a nominal part-time salary. All the men in the clinical departments, even though on a full-time salary, are permitted to have private patients. For most of these the income from professional fees goes to the department budget and is available for salaries, additional members of the staff, and research. The number of beds for private patients in normal times is limited to 5 per cent of the total bed capacity of the University Hospital.

The Dean felt that from his primary interest — medical education — the University Hospital is too large and that 400 to 600 charity beds should be adequate. However, the larger the percentage of charity beds the greater the state appropriation for maintenance must be.

Dr. MacEwen very strongly favored and advised the location of the University Medical School and Hospital on the University campus because of the educational advantages of the general University environment and specifically because of the close relationship with the graduate school and Departments of Biology and Chemistry.

He feels that in his own School and Hospital there are only two disadvantages in the matter of clinical material as a result of the small town: one, the lack of abundant obstetrical patients for teaching; and, second, the relatively small out-patient department averaging approximately 100 visits a day. One reason for the small out-patient clinical department is believed to be the fact that Iowa City is located in the farming section which is relatively well-to-do and in which there are relatively few small towns. Plans are being developed for the improvement of the out-patient clinic after the war. He feels that the number of obstetrical patients can be increased likewise and that it will be possible to work out an affiliation with a maternity hospital in one of the larger cities for further training of students, interns, and nurses. Even with a relatively limited number of obstetrical patients, the Department, from the standpoint of teaching and research, is one of the best in the School and has received a grant from the Rockefeller Foundation for post-graduate training after the war.

We gathered both from discussions with Dr. MacEwen and with a group of doctors in private practice, including the Secretary of the State Medical Society in Des Moines, that there has been from time to time considerable criticism among the medical profession of the set-up at the University Hospital and Medical School. In the first place, Des Moines, being a large city of approximately 200,000, has always felt that the Medical School should have been located there. In the second place, the physicians in private practice have objected to the clinical members of the Medical School faculty being allowed to have private patients. According to Dr. Bierring, Commissioner of Health for the State of Iowa, the feeling in general has improved a great deal in the past ten years and he believes that the Medical School is doing a very fine job in training physicians and that the Hospital is serving a very useful purpose in caring for indigent patients in the State and in training medical students, nurses, and other types of medical personnel.

One has the definite impression that while the criticisms voiced by the physicians in private practice are those heard perhaps in every state and city in which a medical school or teaching hospital is located, it might have been possible in Iowa to have avoided at least part of the dissatisfaction if matters had been handled a little more diplomatically in the beginning.

One cannot but be impressed by the soundness of Dr. MacEwen's ideas and ideals in medical education. His school is well organized, well administered, and seems to function as a well co-ordinated, effective teaching unit.

There is a very close co-operation between the Medical School and the Hospital. This is to be expected, both because of their close physical connection and because Dr. MacEwen is both Dean of the Medical School and Medical Director of the Hospital and of the School of Nursing.

The School is doing a splendid job in medical education and in research and there are many fine features that could be incorporated into the building of a state medical center at the University of North Carolina.

IMPRESSIONS

I. In a more or less rural community, Iowa on its State University Campus has established a fine unit of medical education and a large and effective general, psychopathic and children's hospital.

II. For teaching purposes the out-patient and obstetrical departments probably do not supply entirely adequate material. Plans are being formulated to remedy this situation.

III. The emphasis at Iowa is on the full-salaried department head in the clinical departments but Dean MacEwen recognized some educational and public relations value in permitting limited private practice.

IV. The faculty salary scale is in the general range of that at Michigan.

UNIVERSITY OF VIRGINIA SCHOOL OF MEDICINE

NUMBER 3 OF A SERIES OF SURVEYS BY THE COMMITTEE ON MEDICAL SCHOOLS

CHARLOTTESVILLE—POPULATION 22,000

The Medical School and Hospital of the University of Virginia are located on the campus of the University and form an integral part of the institution. From the outset our Committee was impressed by the atmosphere and the spirit of the institution and by the high caliber of the men in the administration of the School and Hospital and of those in the faculty whom we met.

HOSPITAL

The University Hospital, which adjoins and is connected on each floor with the Medical School Building, has a total bed capacity of 525, of which 375 are ward beds for teaching and 150 are for private patients. There are two wards for psychiatric patients; in addition, only a short distance from Charlottesville is a 350-bed tuberculosis sanatorium which is also available for teaching purposes.

The main part of the hospital is an old building to which wings and pavilions have been added from time to time over a number of years. Parts of the original structure have been remodeled and more or less modernized. It is overcrowded and several of the departments are handicapped by the inconvenient arrangement of offices, laboratories, and wards.

There are two Negro wards — one for male and one for female patients — staffed by white nurses. The State has appropriated $1,000,000 for the construction of a new Negro hospital at the close of the war. Because the hospital has been added to repeatedly through the years it was difficult to get the exact cost of the construction and equipment.

The obstetrical service seemed quite adequate. In 1943 there were approximately 1,100 deliveries, or between 90 and 100 monthly. For many years the University has had a connection with certain Norfolk hospitals for supplementing the obstetrical service. It was the feeling of both Dr. Jordan, the Dean, and Dr. Mulholland, the Assistant Dean, that there is now sufficient obstetrical material for teaching and that if the hospital had additional beds for obstetrics the service would be more than adequate.

Out-Patient Department

We visited the out-patient department in the middle of the morning and, in spite of its being in cramped and rather unattractive quarters, there seemed to be an adequate amount of clinical material. The number of daily visits to the out-patient department throughout the year is around 170.

In the judgment of Drs. Jordan, Mulholland, and Swineford, their difficulty was not in getting enough material for teach-

ing, but in having so much with their curtailed staff that they were not able to do justice either to the care of the patients or to the teaching of the students.

It was not possible to get accurate figures in regard to the distribution of patients entering the hospital either as ambulatory or bed patients. According to Dr. Jordan patients came from all over Virginia — both ward patients and private patients. He estimated that only a very small percentage came from the City of Charlottesville or from Albemarle County.

The counties in the State of Virginia assume no responsibility for the hospital care of indigent patients. Maintenance budget of the hospital was $758,860 for the year 1943.

Dr. Mulholland, who has been chairman of the state-wide committee on hospitalization and medical care for rural sections of Virginia, expressed a great deal of interest in the proposed program of Governor Broughton for North Carolina. He felt that we were attacking the problem in the proper fashion by establishing a medical center and at the same time providing means for a better distribution of hospitals and physicians in the more rural areas.

MEDICAL SCHOOL

The School is housed in a modern and well-equipped building completed in 1929 at a cost of approximately $1,400,000. The funds for equipment and construction of the new building were obtained from the General Education Board, State appropriation, and private donations. The building also provides space for the out-patient department, the X-ray department, and is connected on each floor with the adjoining hospital.

Enrollment

Normally the enrollment of each entering class is limited to 65. Preference is given to natives of Virginia. Tuition for in-state students is $310; for out-of-state students, $360. The legislature of 1942 established four annual medical scholarships each at the University of Virginia and the Medical College of Virginia of an annual stipend of $550 for students who agree to engage in rural practice in the State of Virginia for a minimum period equal to the number of years of medical education financed by the State scholarship.

Budget

The budget for the current year is $345,000, of which Dr. Jordan estimates one-third is from State appropriation, one-third from student fees, and one-third from endowment. This does not include the additional income to the various clinical departments from private practice by members of the staff.

Faculty

The University of Virginia has had over the years many distinguished men on its teaching staff. Its present faculty has an excellent reputation. All of the men in the clinical departments are paid a salary and derive a part of their income from private practice. The salary scale for full

professors is from $5,000 to $10,000. All of the clinical men have their offices in the hospital and are geographically full time in the service of the hospital and medical school. One interesting feature of the salary arrangement at Virginia is the ceiling on individual incomes for all men in the clinical departments. This figure has been set at $15,000 and each member of the staff is permitted to supplement his State salary up to that amount. At the same time he must each month pay 20 per cent of his earnings from private practice to the University for office rent, secretarial services, etc. All income over $15,000 from each member of the clinical staff goes to the departmental budget, is kept separate from the regular State budget and is handled as a trust fund that is used for adding staff members in junior positions, for research, for traveling to meetings, etc. For example, we were told that one member of the staff had a gross income of approximately $50,000 a year. In addition to paying 20 per cent to the University for the use of hospital facilities, all of the income above $15,000 went into the department budget.

According to Drs. Jordan and Mulholland, this system works fairly satisfactorily and for the most part the staff is satisfied. According to some of the younger men there is a great deal of dissatisfaction with it on the basis that they object to contributing so much of their income to the University when they are not provided with sufficient assistance to carry the load of work, both teaching and private practice. They feel that their teaching and professional development is interfered with. We gathered that they do not object so much to the actual ceiling level as to the use the institution makes of the income from this source.

In a conference with President Newcomb, Dr. Jordan and Dr. Mulholland, the question of the location of the Medical School for the University of North Carolina was discussed very frankly. It was the unanimous opinion of these three educators that it would be a mistake if the school were separated from the general University. They felt from their own experience at Charlottesville that clinical material in abundance would be available in Chapel Hill and that the advantages to be gained from the standpoint of medical education far outweighed any possible disadvantage of the location in a small town. President Newcomb and Dr. Jordan said that they had advised representatives from the University of Alabama, University of Mississippi, and the University of Missouri to locate their schools on the university campus rather than moving them to a larger city.

The question of private patients and private practice on the part of the University staff was discussed with Drs. Jordan and Mulholland. They both expressed the feeling that this was an essential function of the State University hospital. They felt that the medical profession in the State approved of their facilities and method of handling private practice.

IMPRESSIONS

1. The Medical School of the University of Virginia has had a long and distinguished

history. In spite of some handicaps in the physical plant, particularly in regard to overcrowding and inconveniences in some of the older buildings, one has the impression of a very fine type of institution that has very high standards of medical education and of medical care.

2. Its location on the University campus, in the opinion of the University and Medical School administration, has been of great educational value.

3. The location of the hospital in a small town once again proves the feasibility of securing adequate teaching material outside of larger cities.

4. While the hospital and the medical staff are undoubtedly carrying a considerable load of the medical services for indigent patients in the State of Virginia, one has the impression that it is primarily a teaching institution and that its services to the low-income groups in the State might be extended.

5. The financial support on the part of the State is inadequate for the Medical School and the Hospital.

Committee visiting the University of Virginia—
DR. DONNELL COBB
MR. R. G. DEYTON
DR. W. R. BERRYHILL

The Committee is indebted to the following for their information and advice:

PRESIDENT NEWCOMB
DR. H. E. JORDAN, *Dean, School of Medicine*
DR. H. B. MULHOLLAND, *Assistant Dean and Professor of Medicine*
DR. OSCAR SWINEFORD, *Associate Professor of Medicine*

THE MEDICAL COLLEGE OF VIRGINIA

NUMBER 4 OF A SERIES OF SURVEYS BY THE COMMITTEE ON MEDICAL SCHOOLS

The Medical College of Virginia began as a department of Hampden-Sidney College in 1838. Since 1860 it has been at least partially supported by the State. In 1913 it was consolidated with the Memorial Hospital and the University College of Medicine, founded by Dr. Hunter McQuire in 1893. For administrative purposes the college is divided into four schools: Medicine, Pharmacy, Dentistry, and Nursing. It is considered a State institution though receiving only a minor part of its financial support from the State of Virginia. The President of the College is Dr. W. T. Sanger. Each of the four schools has its own Dean.

The Medical College of Virginia, with its modern hospital and four schools, is in reality the medical center of Richmond. It is situated in downtown Richmond in a group of buildings scattered over an area of approximately two blocks. The oldest of these, the Egyptian Building, was completed in 1845 and the most recent building, the Medical College Hospital, was dedicated in December, 1940. The departments in the Medical School are scattered in several of the buildings, which probably hinders the efficiency of teaching and gives one the feeling of lack of co-ordination in the activities of the College as a whole. This distribution of activities is in contrast to the rather close unit co-ordination at the University of Virginia in Charlottesville and at the University of Iowa.

Hospital Facilities

The hospital facilities for the Medical School are quite adequate. The most important of the three hospitals is the new 600-bed Medical College of Virginia Hospital, a splendidly constructed and modernly equipped unit. In addition, there is Saint Phillips Hospital for Negroes, an older building accommodating approximately 175 beds, and finally the Dooley Hospital for Negro children. The total cost of the three hospitals, built and equipped over a period of twenty years, was approximately $3,855,000; total bed capacity is approximately 900 beds, of which 155 are for private patients.

Maintenance

The operating cost of the hospital is $1,500,000. Normally the per diem cost per ward bed is $4.50. At the present time it is estimated to be $5.00. The actual charge made for ward patients is $3.35 a day. The State appropriates $180,000 annually for maintenance of the hospital. The City of Richmond contributes $150,000 to $300,000 for care of indigent patients; and approximately $275,000 is raised annually from various sources in the City and the State for maintenance of the hospital. In addition, the hospital has between $1,500,000 and $2,000,000 endowment for maintenance expense. A few of the counties around Richmond pay the hospital for the

care of some of their indigent patients referred to the institution. There is a certain amount of earned income derived from the College power plant which furnishes heat to all the buildings around the Capitol Square in the City of Richmond.

Approximately 46 per cent of the patients admitted to the hospital come from outside of Richmond, and approximately 10 per cent of the dispensary patients come from out of town.

THE MEDICAL SCHOOL

The Medical School is under the immediate direction of Dean J. P. Gray, who is also Professor of Preventive Medicine. The faculty numbers many very capable men in the pre-clinical and clinical departments. The total enrollment of the Medical School is 380 at the present time. Normally the entering classes are limited to approximately 80 students; third and fourth year classes are limited to 100 students each. Tuition for Virginia students is $325 a year; for out-of-state students, $450.

Budget

It was very difficult to get accurate figures in regard to a detailed budget for the School of Medicine. A part of the salaries of members of certain departments in the Medical School is charged to the Schools of Pharmacy, Dentistry, and Nursing because certain departments participate in the instruction of students in all four schools. In addition, a part of the salaries of the teaching staff is charged to the General Hospital budget. The budget as set up with the above mentioned deductions was $297,000 for the year 1943-44. President Sanger explained that insofar as it is possible the expenses of the Medical School are charged to the hospital and the cost of instruction in all of the schools prorated between medicine, pharmacy, dentistry and nursing. The total cost of instruction for all four schools is $801,000, of which $201,000 is State appropriation, $75,000 from endowment and $200,000 from special grants.

Salary Scale

The Medical College of Virginia does not have a definitely established uniform salary scale. President Sanger and Dr. Gray explained in some detail a rather elaborate plan which they hoped eventually to put into effect in which full professors will receive from $5,000 to $7,500; Associate Professors, $4,200 to $4,800; Assistant Professors, $3,400 to $4,000; Associates $2,700 to $3,200; Instructors $2,000 to $2,500. In addition to the salary as teachers, each member of the clinical departments would receive an additional stipend ranging from $250 to $3,000 for hospital and clinical services. This latter stipend would be charged against the hospital and not the Medical School.

In a city the size of Richmond there are, of course, many capable people in the clinical branches who have a part-time connection with the Medical and Dental schools. Some of these have offices in the Medical College of Virginia Hospital and receive only a small stipend from the School; others have their offices downtown and devote a certain amount of time in hospital and

teaching duties in return for the privilege of sending private patients to the hospital. Both administrative officers had the point of view that the institution should undertake some method of controlling or limiting the annual income of each member of the staff. At the present time no definite system has been worked out.

SCHOOL OF NURSING

The School of Nursing is a part of the Medical College of Virginia under the general direction of President Sanger but under the Dean of Nursing as its chief administrative officer. There is a nursing school for white students in the main hospital and one for colored students at Saint Phillips Hospital. It is interesting that in the latter institution over a period of years most of the white supervisors and head nurses have been replaced by competent colored nursing graduates. There still remain a few white instructors and supervisors in the colored institution. Instruction for the white and colored nurses is given separately.

IMPRESSIONS

I. The Medical College of Virginia is a first-rate institution. It is an example of an outstanding medical center in one of the larger southern cities. There is undoubtedly some disadvantage in its location away from close association with a university.

II. It is unfortunate that the preclinical departments are located in several buildings separated from each other and from the hospital and library. The clinical departments are all housed in the hospital. Close physical proximity of the preclinical laboratories, the hospital, and the library would make for a better organization and for more effective work, both in teaching and research.

III. The Medical College of Virginia is doing a splendid job in the field of medical education and in serving the City of Richmond and surrounding counties with splendid hospital service.

IV. A survey of this institution shows what can be done in a relatively large city but obviously many of the conditions found in Richmond are different from those in North Carolina and are not particularly applicable to our problems.

Committee visiting the Medical College of Virginia—

Dr. Donnell Cobb
Dr. W. R. Berryhill—
and later in connection with State Budget Director for Virginia, Mr. R. G. Deyton.

The Committee is indebted to President W. T. Sanger, Dr. J. P. Gray, Dean School of Medicine, and to Dr. W. B. Porter, Professor of Medicine, for their courtesy, information and advice.

To the Committee on the Four-Year Medical School
and the Central Hospital:

It is with pleasure that I herewith render my report on facts concerning the number and distribution of doctors in North Carolina.

Hubert B. Haywood

Hubert B. Haywood,
Chairman

THE NUMBER AND DISTRIBUTION OF DOCTORS IN NORTH CAROLINA

In 1944 North Carolina had a population of 3,571,623. The population is largely rural. There is only one city with over 100,000 inhabitants. Poor housing, poor food, and poor sanitation is responsible for much of the illness in the state. To correct this educational, economic and medical measures must be instituted and carried through.

There is a lack of medical and hospital facilities in the state to meet its needs.

There are 66 counties with hospitals.
Their total population is 3,015,639.
There are 34 counties without hospitals.
Their population is 555,984 (15.6% of total).
There are 2.370 hospital beds per 1,000 population in the state.
16 counties have more than 3 beds per 1,000 (26.5% of total population).
19 counties have 2.5 beds per 1,000 (21.1% of total population).
25 counties have 1.56 beds per 1,000 (28.8% of total population).
6 counties have 0.68 beds per 1,000 (7.8% of total population).

There is obviously an unequal distribution of hospital beds to the needs of the population. The American Hospital Association reports that the adequate number of hospital beds in the nation should be 3 to 5 per 1000.

The number of hospital beds in North Carolina for the Negro population which is 982,108 is 1,631, giving a ratio of 1.66 per 1,000 of population. There are 41 counties which have no hospital beds for the colored race.

Eighty-nine general hospitals in the state received aid from the Duke Foundation to the amount of $419,942.00. These hospitals comprise 84% of all general hospital beds in North Carolina. 15.8% of the days of care of all white patients were free, and 53.5% of all days of care of Negro patients treated in 89 hospitals was free. This means that 69.3% of the hospital patients in North Carolina were unable to pay hospital bills.

Eighty-four per cent of our population, or 3,015,639 people, live in 66 counties and average 2.8 hospital beds per 1,000. Sixteen per cent of the state's population, or 555,984 people, live in 34 counties without any hospital facilities. These figures speak for the need of more hospitals and hospital beds in North Carolina.

The National Farm Foundation Conference which met in Chicago on April 11-13, 1944, and dealt with Medical Care and Health Service in Rural Areas, reached these conclusions among many others which I omit for want of space:

1. Too few physicians, dentists, and other medical personnel in rural areas.

2. Relatively more old physicians in rural areas. (It is held that a physician past 65 years old in a rural area is only 33 1/3% effective.)
3. Low ratio of hospitals and hospital beds in rural areas.
4. Preventive medicine is neglected because most physicians, under present conditions, have no economic incentive to give time and effort to that field.
5. Health education and organization in rural areas have been neglected.
6. Sanitation programs have not been carried far enough in rural areas.
7. A good medical care plan should include all types of medical care, surgery, dentistry, ophthalmology, general practice, prescribed drugs, hospitals, etc.
8. Rural people need most of all a good general physician, preferably not less than one physician for each 1,000 people.
9. The number, size, type and location of hospitals, clinics, and health centers should be determined on the basis of careful planning by public committees. The guiding goal is the maximum amount of service to the most people.

Presumably there might be three size classes of hospitals.

(1) Large central hospitals of from 500 to 1,000 beds to serve a state or any large sub-area of a state.

(2) Intermediate sized or district hospitals of fom 50 to 100 beds to serve districts of from 15 to 30 thousand people.

(3) Small community hospitals or health centers with a small number of beds for emergency cases and for cases not requiring specialized attention in a larger hospital.

Our hospital needs could be met by a similar plan. With the expansion of the two-year medical school at Chapel Hill into a four-year school, a central hospital adequate for the needs of the state and for teaching medical students could be built. It seems to be the consensus that a certain number of rooms should be set aside for private patients in an institution of this type. It is easier to hold a high-class teaching faculty if they are permitted to devote a certain allotted part of their time to private patients. It is desirable for interns and resident physicians to come in contact with some private patients.

A high-class hospital, medical school and faculty is a necessity. Our population must be brought up to the level of the best in modern medicine and most certainly our medical practice and physicians graduated at our state institutions must not and will not be brought down to a low level to meet certain sections of an untrained public ignorant of medical progress.

Rural medicine could be helped by the county or district hospital. The small clinic will fill the needs of many communities.

The young physician who is well trained will be willing to go where he has the advantages of a hospital; otherwise he will not go. About 10 per cent of the younger rural doctors emigrate yearly to the larger centers.

Loan funds should be established to aid poor boys, especially in the rural areas, to enable them to get a medical education. Most of the doctors in the country districts were reared in the country. Loan funds should carry a direct obligation to return to their communities for a certain number of years.

The responsibility for financing a rural hospital should belong in part to the community in which it is located. The interest in it is greater and as a consequence it gets better local support.

The excellent and complete report of Dr. Watson S. Rankin of the Duke Foundation has been mailed to all members of this committee.

In North Carolina with a colored population of 982,108 there are 142 colored physicians. These physicians are located in 48 of our 100 counties. It is obvious that this is an inadequate number. Practically all of them are located in towns and cities.

The State of Virginia which has problems rather similar to our own at the 1944 meeting of their General Assembly voted to contribute to the cost of education of a maximum of twenty-five medical and ten dental students at Meharry Medical School located in Nashville, Tennessee, the sum of $500 per year for each medical student and $400 per year for each dental student.

Meharry has been envisioned as a future regional medical center where all southern states might place their Negro professional students for training. Meharry Medical School took a stride toward this goal recently when it was granted an endowment of $4,300,000 by the General Education Board. The college already has contracts with the State of Tennessee for the training of 30 of its medical students. The faculty of approximately 90 is composed of both white and Negro department heads and instructors. Meharry is the largest and one of the two medical college for Negroes fully accredited by the Association of American Medical Colleges and is rated as "Class A" by the American Medical Association.

North Carolina Physicians and Population

1944 Population	Number Physicians in Active Practice	Ratio
3,346,000	1,638	1 to 1,938
Wake County		
103,369	83	1 to 1,245
Dare County		
4,633	1	1 to 4,633
Swain County		
12,111	3	1 to 4,037

Number of licensed physicians each year in North Carolina from 1940 through 1944:

1940	148
1941	119
1942	138
1943	178
1944	to date 10
Total for four years	593

Average number of medical students graduated from medical schools in North Carolina each year who are residents of North Carolina: about 65; Duke, 20; and Wake Forest, 45.

Average number of prospective medical students with sufficient or adequate pre-medical training to entitle them to admission to a Grade A medical school: 130.

Average number of physicians who die or retire in North Carolina each year: 50.

Average need for new physicians in order to maintain present ratio approximates 100 each year. Many of these new physicians go into specialties and do not serve the general, especially the rural, public. There are 24 specialties listed in the Directory of the American Medical Association.

The ideal prescribed by the American Medical Association is one physician to every 800 to 1,000 patients. Our average at its very best before the war approximated one physician to every 1,600 patients.

Our two medical schools at their best do not take care of the education of our new physicians who are needed to supply our present medical needs and maintain our present ratio by at least forty to fifty new physicians each year. The majority of these men receive the first two years of their medical education at the Medical School of the University of North Carolina and go out of the state for the last two years of their medical education. The two schools in the state could not well absorb the fifty or more men who yearly graduate at Chapel Hill.

A medical education out of the state is more expensive to a North Carolinian than one within the state. Thus many poor boys are denied the privilege. Many of the best graduates who go out of the state are offered attractive positions in other states and never return to North Carolina to practice.

Good pre-medical preparation has reached such perfection that relatively few medical students are dropping out of medical schools. This causes a lack of vacancies in good medical schools. This ultimately means the doom of the two-year schools because there will be no openings for their graduates in Grade A schools. The graduates of the school at Chapel Hill have been the backlog of the medical profession in North Carolina. Nationally it is known as a first-class school with good and modern equipment and an excellent faculty.

There is a definite need in North Carolina for the fifty or more graduates of this school each year. If the school is abolished our medical deficit will increase. The school can readily be expanded into a four-year school of real excellence and distinction. The state of Virginia to our north supports two state-aided medical schools, the state of South Carolina one and the state of Tennessee one.

SUMMARY

North Carolina population—3,571,623

Present physician to population ratio—1 to 1,938

Desirable ratio—1 to 1,000

Colored population—982,108

Colored physicians—142

Ratio of colored physicians to population—1 to 6,916

Total number of counties in North Carolina—100

Total number of counties with hospitals —66

Total number of counties without hospitals—34. (Their population is 555,984.)

Total number of hospital beds in North Carolina per 1,000 population—2.37. (The ideal is 3 to 5 beds per 1,000.)

The number of hospital beds for Negroes per 1,000 population—1.63

There are 41 counties with no hospital beds for Negroes.

Eighty-nine general hospitals received $419,942 from the Duke Foundation last year for charity patients. These comprise 84% of all general hospital beds in North Carolina.

15.8% of the days of care of all white patients was partially free.

53.5% of all days of care of Negro patients was partially free.

There is an unequal distribution of doctors in the State. The young and best trained physicians go where there are medical advantages and hospital facilities. Our two medical schools with about 65 yearly graduates do not graduate enough doctors each year to supply our needs. The ratio of physician increase has not kept up with the ratio of population increase.

There is a need for a Class A state-supported medical school and central teaching hospital to help fill our yearly physician deficit. The hospital beds are needed not only for teaching purposes but also to take care of our hospital cases who lack proper facilities at the present time.

The problem of Negro medical education is a real one. A regional Negro educational center such as Meharry offers a solution.

Conclusions

Increased hospital facilities are necessary. Increase in the number of physicians in North Carolina is a necessity. It would be a calamity to sit still and await the ultimate fate of the closing of the two-year medical school at Chapel Hill. One of our best sources of physicians in North Carolina would be lost. It is practical and necessary in order to meet our demands for physicians in North Carolina to expand it into a four-year school. The solution of this problem is bigger than the mere founding of hospitals and a medical school. It is one which profoundly affects the social and economic life of North Carolina.

Signed: HUBERT B. HAYWOOD,
Chairman

SOURCES OF INFORMATION

Hon. J. M. Broughton, Governor of North Carolina
Dean Davison of Duke University
Dean Carpenter of Bowman Gray College
Dean Berryhill of Chapel Hill
Dr. W. S. Rankin of the Duke Foundation
Mr. Alexander Webb of Raleigh
Mr. A. B. Andrews of Raleigh
Dr. G. Horace Hamilton of N. C. State College
Rural Sociology March 1944
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National Physicians Committee

The Journal of The American Medical Association

Commonwealth of Virginia. Division of Statutory Research and Drafting

Dr. Carl V. Reynolds, Secretary of North Carolina State Board of Health

Dr. Clarence Poe, of Raleigh, N. C.

The Secretary of The Negro State Medical Society

Mr. Robert Deyton, Director of the Budget, Raleigh, N. C.

Mr. Harry McMullen, Attorney General, Raleigh, N. C.

Dr. Roscoe McMillan, Secretary North Carolina Medical Society

Dr. W. D. James, Secretary of the N. C. Medical Examining Board, Hamlet, N. C.

Dr. Paul McCain, Chairman of the Governor's Commission, and other members

Miss Elizabeth Holloway, Research Student N. C. State College

TO YOUR GOOD HEALTH

A proposed program dedicated to the good health of every citizen in North Carolina.

By Carl V. Reynolds, M.D.

AN ENLARGED AND ADEQUATE PUBLIC HEALTH PROGRAM FOR ALL NORTH CAROLINA

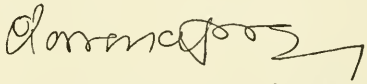
By Carl V. Reynolds, M.D.

Public Health Program For North Carolina

A MAJOR recommendation of the State Hospital and Medical Care Commission is the following:

> "Appropriations for public health work should be increased until the state has entirely adequate program for the prevention of disease, thus reducing needed hospital and medical care to the lowest practicable minimum."

The great possibilities of such a policy are here vividly set forth by Dr. Carl V. Reynolds.



CLARENCE POE, *Chairman*
North Carolina Hospital and
Medical Care Commission.

EVERY CHILD is entitled to be born with a sound mind in a sound body, in order that he may compete for his rightful place in the world. We have seen the results of depraved minds in high places—the former Kaiser of Germany and his successor, Hitler; Mussolini of Italy—and the wild chaos they created among their own subjects with their paranoia, involving the world in two wars that threatened the very foundations of civilization.

To be physically fit, we must be mentally fit; to be mentally fit, we must be morally fit, and to be morally fit, we must be basically healthy. Hence upon health depends mankind's ultimate well-being. Upon the citizen's moral, mental and physical structure rests the economic foundation of the State and the Nation.

Our people are conscious of their medical needs and appreciate their importance as basic in life's plan. But to supply these needs there must be provided the necessary means, in the form of supplemental medicine, which is not charity, state medicine, socialized medicine or contract practice, but simply guarantees the physical, moral and mental freedoms to those who are not able to pay for that which provides them in fullest measure.

Curative and Preventive Medicine

We spend our millions for schools, roads and other intellectual and economic necessities; through the various organizations to which we belong, make private contributions to the religious and the cultural life of our people. But to what extent will all these things furnish real pleasure and enjoyment, unless we are basically healthy? And to be basically healthy, we must be the beneficiaries of ample provision for health, not only through private endeavor, but through the fulfillment of our public obligations—our obligations one to another, as members

of a common society, the various elements of which are so interdependent as to be inseparable. The injunction, "Bear ye one another's burdens," is basic, and we cannot escape the obligation it imposes.

There are two forms of medicine—the curative and preventive—the over-all plan of caring for and rehabilitating our people, and making medical and hospital services available to all who need them, regardless of their economic—or wage-earning—status. This applies to the mental, as well as the physical.

The successful promotion of both curative and preventive medicine must rest upon the realization that these are interdependent, and that the success or failure of one means the success or failure of the other.

Public Health Funds: State $439,000; Other, $1,764,000

It is an established fact that it is necessary to have $1 per capita in order to maintain a minimum public health program. Many years have elapsed since 1877, when the State Board of Health was created by Legislative enactment, with an annual appropriation of $100. During the fiscal year ending June 30, 1944, there was expended under the supervision of the State Board of Health, for all purposes, the sum of $2,203,805. This sounds like a huge sum, but is dwarfed by expenditures for many other purposes, none of which *could be* more important than public health—and some not nearly so basically important. *Of this $2,203,805 only $439,213 came from state appropriations, the remaining $1,764,592 from the Federal Government, private philantrophies, and miscellaneous sources, including $178,188 from the Reynolds Foundation for use in fighting venereal diseases.*

For the present fiscal year the counties and cities of the State are contributing $1,378,323 to the cooperative public health program,

while Federal funds are budgeted in the amount of $2,205,541 while the state appropriation stands at only $457,516.

What Public Health Service Can Do

The standard maximum state allotment for a full-time local health unit during the depression year of 1932-33, when there were only 43 such units in North Carolina, was $2,400. At the present time, there is available only $150,000, to be spread over 91 counties with full-time health departments. If this were prorated on a basis of 100 counties, it would mean only $1,500 a county, in the face of growing needs and added responsibilities to our people. Already the local health units are serving 95 per cent of the entire population. It is felt that an additional new appropriation of $350,000 for each year of the coming biennium would be a fair figure, and that by providing it the State would be assuming only its rightful responsibility in supporting the public health organization. An appropriation from the State of $500,000 would be but a fraction of the amount being contributed by the counties for local health services.

Tuberculosis control, cancer control, nutrition and crippled children's work also warrant additional state funds, if this work is to be expanded to meet necessary requirements.

Approximately $10,000,000 for *tuberculosis control* has been appropriated by the Federal Government, and if North Carolina sets up a definite bureau to direct these funds, it will receive an estimated several hundred thousand dollars. On a matching, certainly on a cooperative, basis, it is felt that the state should furnish, at the state level, a budget sufficient in size to direct funds coming in from the Federal Government. The time has come in North Carolina when we can no longer

forget or ignore the open case of tuberculosis at large, as a carrier of the disease.

Special funds will become available for *cancer control,* and we should be prepared, with the proper bureau, if we expect to have the advantage of these funds. It would be an outstanding advance in cancer control to make available at the State Laboratory of Hygiene a tissue examination for diagnostic purposes. This is essential to the success of the program, as biopsies are now outside the financial reach of many.

Nutrition must play an important part in the post-war maintenance and rehabilitation of our people. While we have made a good start with the means available—coming for the greater part from outside sources (the Rockefeller Foundation)—state funds should be provided for a long-range program, as nutrition plays and will continue to play a very definite role in preventive medicine.

Thousands of children already have been reclaimed through the work of the Board of Health's *Crippled Children's Department.* Corrections are constantly being made for hare lips, cleft palates, bone diseases, burns, injuries at birth, congenital joint trouble, club feet, bowed legs and many other conditions which will continue to call for remediable measures. Many children needed and have been given orthopedic treatment as the result of the 1935 poliomyelitis epidemic in North Carolina. We have just passed through an epidemic of even larger proportions, the crippling results of which have not yet been fully appraised. We should be prepared to meet whatever added responsibilities this imposes upon us, and this can be done only with sufficient funds.

During the past two years, the State Board of Health has supervised 414 clinic sessions for crippled children, 2,414 were admitted to

22 selected hospitals for treatment; and, on June 30, last year, 23,339 children in need of orthopedic services had been located and their names placed on the state register.

Beyond question, one of the most important links in the public health chain in North Carolina is *the State Laboratory of Hygiene.* For the fiscal year ending June 30, 1944, the cost of operating the Laboratory was only $128,885.17, though this institution saves the taxpayers of North Carolina an estimated $2,500,000 a year, based on what they would have to pay at commercial prices for the services it renders them. Yet of this total the Laboratory itself earned $63,645.33, leaving only $65,240 coming from the state appropriation.

Recent Public Health Achievements

Let us consider briefly some of the advances we have made through mass protection. Death rates from controllable and preventable diseases in North Carolina fell last year to new levels—diphtheria to 1.5, typhoid fever to 0.5, tuberculosis in all forms to 39.1, pellagra to 3.0, malaria to 0.6 (all per 100,000). Compare these with the death rates from the same diseases a generation or even a decade ago, and the results in some instances will prove nothing short of amazing.

Although the rates still are too high, there seems to be a sustained downward trend in both maternal and infant mortality. Public health takes a justifiable pride in this, because it operates, at strategic points throughout the State, 200 maternal and child health clinics, where during the past two years, 20,757 babies were examined and 8,784 pre-school examinations were made. There were, in addition, 22,380 prospective mothers examined, approximately 8.1 per cent of whom were found to be syphilitic, compared with 13 per cent four years ago —a decline of 4.9 per cent.

Also, during the past two-year period the State Board of Health's Oral Hygiene Division gave 21,592 classroom lectures in the schools of the State on mouth health. These were attended by 116,678 children. Of these more than 47,000 who were underprivileged were treated and 51,000 whose parents were able to pay were referred to practicing dentists.

Public health is keeping track of North Carolina's venereal disease incidence with increasing efficiency. For two years prior to June 30, 1944, the State Laboratory of Hygiene made 1,095,000 serologic tests, and 1,049,000 during the previous biennium. The number of treatments given in the State's 310 public health clinics since 1939 has totaled 3,304,000, compared with approximately 1,500,000 the preceding four years.

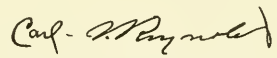
Health Service Needed in 100 Counties

We take pride in the manner in which our State health organization mobilized for war, after a period during which preparedness was emphasized and re-emphasized, beginning in earnest in May, 1940, when it appeared inevitable to many that we were headed toward active participation in the world conflict. We should also mobilize for the peace that is to follow, which will be marked by added, and often heart-rending, problems. We must meet this situation, prepared to cope with it, both financially and in the matter of trained personnel.

North Carolina last year recorded a general death rate of only 8.1 (per 1,000), being the lowest in our history despite war conditions, and more than two points below the death rate for the United States as a whole. This has been accomplished through mass protection, and it is logically sound to assume that this is the proper procedure to follow.

As previously stated, we now have 91 counties in North Carolina with qualified health organizations, either on a unit or a district basis.

It is high time that the present Legislature take under serious consideration the enactment of a law requiring all of North Carolina's 100 counties, through some form of taxation, to provide funds for a minimum health organization, either on a unit or district basis.



Carl V. Reynolds, M.D.
Secretary, State Board of Health.

"THE ULTIMATE PURPOSE of this program should be that no person in North Carolina shall lack adequate hospital care or medical treatment by reason of poverty or low income."

J. Melville Broughton

GOVERNOR

THESE RECOMMENDATIONS of the Governor, proposing a plan for adequate medical care and hospital service for all North Carolina, were presented to the Board of Trustees of the University of North Carolina, on January 31, 1944. The recommendations were endorsed unanimously by the Board of Trustees . . .

To the Board of Trustees
of the University of North Carolina:

The medical profession of North Carolina, and indeed of the entire nation, is rendering perhaps its most notable service in the war program in which our nation is now engaged. Through a procurement committee composed of members of the North Carolina Medical Society, doctors from this state have been promptly made available in numbers exceeding the quota for the State. Through a similar committee of the North Carolina Dental Society an equally gratifying record has been made by the members of the dental profession.

Those members of the medical profession who have entered the armed services of the nation have already acquitted themselves in such manner as to reflect great credit not only upon the profession but upon the State. Their achievements are a part of the brilliant chapter that will constitute North Carolina's conspicuous place in the history of this greatest of all wars.

The entry of so many members of the medical profession into the armed services of the nation has imposed upon the doctors remaining for civilian practice a very heavy burden, which they have cheerfully assumed. In some sections the burdens falling upon the doctors at home have been tremendously heavy, but they have been borne without complaint. In several sections of the state doctors have worked beyond the limit of human endurance, and it is not too much to say that some of them have sacrificed their lives in the effort to fulfill their added responsibilities.

This much is said by way of emphasizing the high quality of citizenship and patriotism displayed by the medical profession in this emergency, as in times past.

There is grave concern on the part of all members of the medical profession in all its various branches over the prospect of what is broadly termed "socialized medicine." Bills are now pending in Congress which in the opinion of the profession and of many thoughtful laymen would strip the medical profession of many of its noble and traditional attributes, deprive patients of the time-honored privilege of personal selection in the matter of medical service, and subject the whole field of medical practice to the uncertain and unsatisfactory manipulations of politics. While such prospect is naturally viewed with apprehension, it is at the same time fully recognized by the profession that certain broad and deep trends in the field of social welfare as affecting medical service cannot and should not be resisted. These conditions spring from a deep-seated feeling that good health and adequate medical attention should be the right and privilege of every man, woman and child, regardless of race, condition or financial circumstances. It is manifest that we cannot attain to that high degree of health essential for national well being and economic prosperity if adequate medical service is limited only to those who are financially able to pay for it. In many instances great industries have recognized the wisdom of this course and have under cooperative arrangements set up plans whereby the humblest employee can obtain adequate medical attention without being called upon to bear the financial burden. However, a large segment of our population cannot obtain the benefits of such individual arrangements which can only apply to those engaged in such industries.

It accordingly would seem wise under a suitable basis of cooperation between the Federal Government, the respective state governments, local governments and various foundations and funds to make provision for adequate medical care and service to those of our citizenship who by reason of unemployment or low income are unable to provide this service for themselves. It is gratifying to note that the medical profession in North Carolina in its organized capacity as the North Carolina Medical Society is wholly in accord with such steps as may be necessary to bring about this condition. This Society is not only favorable to such general plan, but would be glad to join in the sponsorship of any move that may be made in this direction.

It is believed that the University of North Carolina, which already has a standard two-year medical school and has recently had its medical facilities substantially enlarged in connection with the Navy program, should join in

sponsoring such proposal. In fact, it is felt by officials of the Medical Society and by many who have given consideration to this matter that the University should have an active part in any plan that is proposed.

I have conferred with the officials of the Medical Society and with others who have studied this whole subject, and I recommend for the consideration of the Board of Trustees and for later action by the General Assembly of North Carolina, if such plan should be approved by this Board, the following:

1. That the present two-year medical school at the University be enlarged and increased so as to provide a full four-year course. Two other medical schools in the State—Duke University and the Bowman Gray School of Medicine of Wake Forest College at Winston-Salem—are already on a four-year basis and doing magnificent work; but it is obvious from a study of the figures that these schools do not begin to supply and can never supply the full requirements for physicians to serve adequately the civilian population of North Carolina.

2. That an adequate hospital be erected at the University of North Carolina at Chapel Hill, with a capacity of not less than six-hundred, and preferably one-thousand beds, which in conjunction with the Medical School and the hospital facilities already available at the University shall constitute a state hospital center; that such hospital shall be built by State funds, supplemented by such Federal, private or foundations funds as may be available, and shall be open to patients from all sections of the state, with provisions for free hospital and medical service to all such patients as may be unable to pay for same; that the various counties of the state be encouraged and set up appropriations to provide a substantial portion of the cost of patients who may be sent to such hospital from such county, such funds to be supplemented by funds that may be available from the Duke Foundation or other foundations now in existence or hereafter created for such purpose.

3. That since it is obvious that one hospital center could not begin to serve the needs of the state under this sort of program, that other, though smaller, hospitals to serve as local medical centers be established in strategic regions of the state for the hospitalization of those in need of medical care without the means to provide for that care. It is possible that some of the Army or Navy

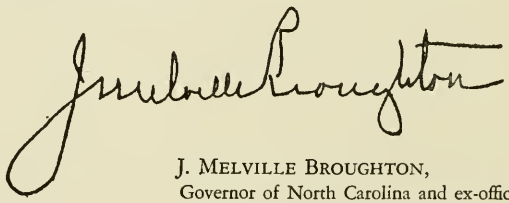
hospitals that have been built in the state in connection with military and naval installations, or otherwise, may be available in connection with this program.

In the event such plan as herein broadly suggested without specific details, should be approved at least in principle by this Board of Trustees, it would be my purpose to appoint a commission to be composed of outstanding members of the medical profession and of business, agricultural and labor groups, to make a comprehensive study of the whole subject, including studies and possible visits to other sections in which achievements along this line may have been made, and to submit recommendations to the next session of the General Assembly, the report of such commission to be filed and made public at least thirty days before the convening of the next session.

The ultimate purpose of this program should be that no person in North Carolina shall lack adequate hospital care or medical treatment by reason of poverty or low income.

I have conferred fully with officials of the North Carolina Medical Society and with a number of other medical authorities, as well as public spirited laymen of the state concerning this whole subject. I attach hereto a comprehensive statement that has been filed with me by a committee, including the present president, the incoming president, and other former presidents of the North Carolina Medical Society, who have given assurance that a program along the lines herein suggested and more fully referred to in their statement will have the heartiest support of the North Carolina Medical Society.

Respectfully submitted,



J. MELVILLE BROUGHTON,
Governor of North Carolina and ex-officio
Chairman of the Board of Trustees of the
University of North Carolina.

A COMMITTEE from the Medical profession of North Carolina, including the President, the President-elect and past Presidents of the Medical Society, submitted the following statement to the Governor . . .

To the Governor of North Carolina
from a Committee of the Medical Profession:

One of the most important problems facing the State and the medical profession is that of providing opportunities for more adequate medical care in the post-war period for all groups of citizens. Some provision must be made for the low-income group to have adequate medical care at fees they can afford to pay and for the indigent to receive both hospital and ambulatory medical services.

In any attempt to solve this problem we are immediately faced with critical shortages of general hospital facilities and trained medical personnel of all types. In 1941 North Carolina, the 11th largest state and the 5th most rapidly growing, stood in 42nd place, tied with South Carolina, in the number of general hospital beds per thousand population and in a comparable position in the number of doctors. In addition, we have always had in this State too few trained medical personnel—nurses, dietitians, doctors of Public Health, sanitary engineers, sanitarians, medical technicians, and health educators. To quote Dean Davison of Duke University Medical School, "The South needs twice as many doctors and three times as many hospital beds" to raise medical facilities to the average for those of the country as a whole which probably will not be an adequate standard for medical needs of the State in the future.

Much progress has been made in the last few years in improving the facilities for medical care and hospitalization for patients with tuberculosis and mental diseases, although there is still a great need for additional hospital beds and additional trained personnel to care for patients with these two types of disease.

That the problem is too large and complex for any one group of individuals or institutions to satisfactorily and adequately solve seems obvious. It is a responsibility and obligation and an opportunity of the entire community, that is, the State. In spite of the magnificent contributions of the Duke Foundation, of private general hospitals throughout the State, including those of Duke University and the North Carolina Baptist Hospital of the Bowman Gray School of Medicine, and the private practitioners of Medicine toward this end, the problem is still acute. Any comprehensive plan which would insure an opportunity for complete high-standard medical services for indigent patients

and for the low-income group must be coordinated with existing health and medical agencies in the State; "must have the active and guiding cooperation of the medical profession"; must provide an increase in hospital facilities, opportunities for training all types of medical personnel and opportunities and support for research into medical problems affecting the health of this section. It would require the financial and moral support of Federal, State, county and municipal agencies as well as that of private philanthropists.

As the first step in a far-reaching program of providing better medical facilities, the following proposals are presented:

1. The building of a large well-equipped general hospital, initially 500 to 700 beds, in a more or less centrally located place in the State to serve as a diagnostic and treatment center for indigent patients who might be referred by social welfare agencies or private physicians from all over the State, both for those needing hospitalization and for ambulatory patients. There should be facilities in the out-patient department adequate for examining large numbers of the latter daily. Patients certified as indigent by their county or city welfare officer would be treated free or for a small nominal registration fee. Patients referred by their physicians and financially able to pay would be charged on a fee schedule, the income to go to the hospital maintenance.

The bed capacity of the hospital should be largely reserved for ward patients, although there should be a small number of semi-private and low-cost private rooms for hospitalization of referred patients in the low-income group. More expensive private rooms should be kept at a minimum.

A system of transportation by ambulances or buses sent from the hospital on different routes throughout the State might be worked out to bring patients to the hospital. A similar plan has been successfully operated in the State of Iowa for many years.

Such a general hospital for the State would logically be placed adjoining the present buildings of the Schools of Medicine and Public Health and the Navy Hospital on the campus at the University at Chapel Hill. The present two-year Medical School, now adequately housed in a new building representing an outlay of approximately $500,000, should be expanded into a four-year

School of Medicine and the clinical teachers of the Medical School should serve as the professional medical staff of the hospital.

A hospital of the size indicated would supply adequate clinical material for teaching classes of 50 or more medical students. Past experience has shown that the best progress in Medicine is attained through the maintenance of the closest possible physical and spiritual relationship between patient, "student" (teacher, student, investigator), library, and laboratory, including the science laboratories of Chemistry, Physics, and Biology, best afforded by universities. Thus, the hospital should be integrated with the Schools of Medicine and Public Health and other facilities at the State University and would undoubtedly work in close cooperation with the State Health Department and with the other State hospitals and agencies devoted to medical care and the improvement of the general health of the State.

In effect this would establish a great North Carolina medical center which primarily would provide medical services to the indigent and train needed medical personnel of all types—doctors of medicine, doctors of public health, nurses, public health nurses, sanitary engineers, sanitarians, hospital administrators, medical technicians, dietitians, social workers, and perhaps dentists. In addition such a center would serve the practising physicians in the State on a postgraduate level enabling them to secure additional training and to keep abreast of progress in Medicine. It would be a central laboratory for research in Medicine and Public Health. The trained personnel and facilities of such an institution would be of great value in performing certain specialized services to the State tuberculosis and insane institutions. In time institutes for the study and treatment of cancer, of nutritional problems, of tropical diseases, an important problem in the post-war period, of mental diseases and many others might be added and thus enlarge the services to this State and section.

2. Obviously, one hospital could not care for all the indigent in the State who need medical attention. From time to time smaller hospitals, well equipped for diagnostic work and treatment, should be set up in different sections of the State in which there are now no hospital facilities. In certain sections existing hospitals might be enlarged. The professional direction of these additional hospital facilities should be in the hands of the medical profession in those

communities and sections of the State. A well coordinated plan could be worked out between the smaller hospitals and the larger central unit whereby the latter could supply professional consultation when requested, or obscure cases in the former presenting problems in diagnosis or treatment could be sent to the central hospital for study.

The building of small hospitals in areas where no such institutions exist and the enlargement of some of the present hospitals would not only provide vitally needed medical facilities but would tend to attract young graduates of Medicine and all other types of trained medical personnel to those areas to begin the practice of their profession. This would help greatly to improve the maldistribution of medical personnel in the State; to further encourage this movement the State might follow the plan of the Commonwealth Foundation and offer a certain number of scholarships to men and women who would agree to return to rural districts and small communities for a certain number of years.

Such a plan, well developed, operated judiciously in a coordinated undertaking with existing State health agencies under the general direction of and with the enthusiastic support of the medical profession, might eventually provide an opportunity for adequate medical services for the citizens who have not been able to afford this service. Furthermore, it might well serve as a model for other states and for the nation as a whole in improving the health and the general usefulness of our people. This tentative proposal should be a part of an overall plan sponsored by the profession of the State in cooperation with public and private agencies and individuals looking toward the eventual solution of the problem of providing complete medical care for the low-income and indigent groups of our citizens.

COMMITTEE: DR. P. P. MCCAIN, *past President State Society, Chairman*
DR. JAMES W. VERNON, *President, State Society*
DR. H. B. HAYWOOD, *past President State Society*
DR. DONNELL COBB, *past President State Society*
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